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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 5, 2018	2018_679638_0010	008767-18	Resident Quality Inspection

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

RYAN GOODMURPHY (638), AMY GEAUVREAU (642), SHANNON RUSSELL (692), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 22 - 25 and 28 - 30, 2018.

The following intakes were inspected during this Resident Quality Inspection:
-One log was related to compliance order (CO) #001 from inspection report #2017_669642_0017, s. 69 of the Ontario Regulation (O. Reg.) 79/10, specific to weight changes; and
-One log was related to CO #002 from inspection report #2017_669642_0017, s. 8 (1) of the O. Reg. 79/10, specific to policies to be followed.

During the course of the inspection, the inspector(s) spoke with The Administrator/Director of Care, Director of Therapeutic Services, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Training and Orientation

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

5 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 69.	CO #001	2017_669642_0017	681
O.Reg 79/10 s. 8. (1)	CO #002	2017_669642_0017	642

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

Resident #003 was identified as being incontinent in their most recent Minimum Data Set (MDS) assessment. The MDS assessment indicated that the resident had a specific type of incontinence during the assessment period. The Inspector noted that the resident's continence status had changed in one of their previous MDS assessment.

Inspector #638 reviewed resident #003’s health care records and identified in their care plan that the resident was incontinent. The Inspector was unable to identify any completed assessments related to the resident’s incontinence.

In an interview with Inspector #638, PSW #107 indicated that resident #003 was incontinent at times and required assistance for toileting. The PSW stated whenever a resident's continence status changed, they would notify registered staff who would assess the resident and determine their needs.

During an interview with Inspector #638, RN #102 indicated that whenever a resident’s continence status changed registered staff completed a continence assessment which was documented in Point Click Care (PCC). The RN indicated that resident #003 was frequently incontinent and required staff assistance for continence care.

The home’s policy titled “Continence Care and Bowel Management Program - CN-C-32-1” last reviewed September 2017, indicated that if an assessment was required due to a change in their level of continence, the continence assessment tool was used.

In an interview with Inspector #638, the Administrator indicated that whenever a resident’s continence status changed, a continence assessment would be completed and documented under the assessments tab in PCC. The assessment would determine the resident’s type of incontinence, patterns, cause and identify the potential to restore continence. The Administrator indicated that resident #003 was incontinent at times and generally required assistance with toileting. Upon reviewing resident #003’s health care

records, the Administrator stated that they were unable to locate a completed continence assessment for resident #003 and indicated that staff should have completed one. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #003 and every other resident who is incontinent, receives an assessment using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

Inspector #681 observed resident #012 being assisted to the dining room for a meal service by PSW #110. The Inspector observed PSW #110 was wearing a surgical mask while they were assisting resident #012 to the dining room.

During an interview with Inspector #681, PSW #110 stated that they were wearing a mask because resident #012 had a cough and that they "didn't want to get it".

In an interview with Inspector #681, resident #012 stated that they were feeling unwell, had a cough and thought that they "had the flu".

Inspector #681 reviewed resident #012's electronic health care records, which indicated one day earlier that resident #012 had a cough accompanied by a fever and that specific medications were administered to treat the resident.

The home's policy titled "Outbreak Protocols", last reviewed April 2018, indicated that residents presenting with symptomatic cases should be isolated. The policy also indicated that the residents presenting with symptoms are to stay in their room until cleared to come out by Public Health.

During an interview with Inspector #681, the Administrator stated that when a resident has experienced two or more respiratory symptoms of infection, the process was to try and isolate them from the rest of the residents in the home. The Administrator stated that a resident with two or more respiratory symptoms of infection should not be sitting in the dining room with other unaffected residents. The Administrator stated that resident #012 should not have been brought to the dining room. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident’s right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference was fully respected and promoted.

During an interview with Inspector #638, resident #001, #002, #003 and #013 each identified that they did not have privacy when making phone calls. Each resident indicated that they were required to make personal calls from the nurses’ station, which was always very loud and there were always residents and staff in the area, which did not afford them privacy.

Inspector #638 observed resident #014 and resident #001 at the nurses’ station at different times, making phone calls. The Inspector noted in both instances, that there were staff and residents in the vicinity and the Inspector could overhear the phone conversation.

In an interview with Inspector #638, PSW #107 indicated that residents could use the phone at the nurses’ station to make phone calls. The PSW stated that there was no way of ensuring that this area was kept private to make confidential calls.

During an interview with Inspector #638, RN #102 indicated that residents used the phone at the nurses’ station to make calls and used the physician’s office if privacy was required. The RN was unsure if the residents were aware of this option.

The home’s policy titled “Residents’ Bill of Rights - CA-02-11-1” dated May 2010, indicated that the licensee of the long-term care home shall ensure that every resident’s right to communicate in confidence, in private with any person without interference was fully respected and promoted.

In an interview with Inspector #638, the Administrator indicated that residents who did not have their own phones could use the phone at the nurses’ station. The Administrator indicated that this was not a private location to make calls and stated that the physician’s office or their own office would be provided if a resident requested privacy. The Inspector reviewed with the Administrator that each of the aforementioned residents were not aware that this was an option. The Inspector inquired if residents' rights were fully promoted, to which the Administrator responded that they should ensure this option was known to everyone, to promote their rights. [s. 3. (1) 14.]

WN #4: 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 where the Long-Term Care Homes Act (LTCHA) or Ontario Regulation (O. Reg) 79/10, required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, s. 68. (2) (e) (ii), the licensee is required to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record, with respect to each resident, body mass index and height upon admission and annually thereafter.

Through record review, Inspectors #638, #642, and #681 identified that resident #001, #002, #003, #004, #008, #011, #013, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026, and #027, had not had their height measured annually, within the previous year.

During an interview with Inspector #681, RD #103 stated that heights should be measured annually, but they did not know if annual heights were being completed because they were not involved in this process.

The home's policy titled "Height", last reviewed May 2017, indicated that residents were to have their height measured annually, using the same method as admission and/or the previous year and documented in Point Click Care.

During an interview with Inspector #681, the Administrator stated that heights were supposed to be measured on admission, updated annually and that all the heights were usually measured during the month of January and were documented in the weights/vitals tab on PCC. The Inspector reviewed the aforementioned residents' recorded heights with the Administrator, who indicated that heights would have been documented in the weights/vitals tab on PCC. [s. 8. (1) (b)]

WN #5: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and that the person who applied the device and the time of application were documented.

According to s. 33. (6) of the LTCHA, 2007, if a Personal Assitance Service Device (PASD) is being used to restrain a resident rather than to assist the resident with a routine activity of living, s. 31 of the LTCHA, 2007, applies with respect to the use.

Resident #004 was identified as having a potential restraint while using their assistive device by Inspector #638 during an observation. Inspector #681 reviewed resident #004's health care records and identified in their care plan that the resident had a specific intervention applied while using their assistive device. The resident's care plan identified that the device was considered a PASD.

In an interview with Inspector #681, resident #004's SDM indicated that the resident had a specific PASD intervention applied while using their assistive device as per their request, for a specific reason.

During an interview with Inspector #681, PSW #111 indicated that checks on resident #004's specific PASD intervention were to be completed every hour and that the resident had to be repositioned every two hours. PSW #111 stated that the monitoring and repositioning of resident #004 were to be documented on the restraint or PASD restraining flow sheets, which were located in the restraints binder.

Inspector #681 reviewed the "Restraint or PASD Restraining Flow Sheet" for resident #004 for the month of May 2018, and noted that the documentation had not been completed on three specific dates, related to the monitoring and repositioning of resident

#004 while their PASD was applied.

The home's policy titled "Restraints", last reviewed August 30, 2017, indicated that staff document the monitoring of restraints or PASD with restraining properties and the releasing of the device and repositioning of the resident on the Restraint/PASD with Restraining Properties Flow Sheet.

During an interview with Inspector #681, RN #102 stated that resident #004's specific intervention was a PASD and that PSWs were to document the monitoring and repositioning of resident #004 on the restraint or PASD restraining flow sheet. RN #102 verified that documentation had not been completed on three specific dates, related to the monitoring or repositioning of resident #004 and that this documentation should have been completed.

During an interview with Inspector #681, the Administrator stated that the restraint or PASD restraining flow sheet should have been completed on three specific dates, because resident #004 was using their assistive device on these days. [s. 110. (7) 5.]

Issued on this 5th day of June, 2018

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

Original report signed by the inspector.