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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2018	2018_746692_0018	031579-18	Complaint

Licensee/Titulaire de permis

675412 Ontario Inc.
3700 Billings Court BURLINGTON ON L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée

Northview Nursing Home
77 River Road P.O. Box 1139 ENGLEHART ON P0J 1H0

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 3-5, 2018.

The following intakes were inspected upon during this Complaint inspection:
- One intake related to alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, reviewed relevant health care records, the home's complaint log, internal investigation notes, as well as the licensee's policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A complaint was submitted to the Director regarding an alleged incident; whereby, resident #001 was exhibiting an identified responsive behaviour towards resident #002, in which resident #002 sustained an injury.

A review of resident #001's electronic progress notes revealed that during a three month period, resident #001 had exhibited an identified responsive behaviour on seven separate occasions. Staff completed a specified intervention successfully on each occasion without incident.

Inspector #692 reviewed resident #001's care plan, which identified a focus of responsive behaviours. The Inspector was unable to identify any focus related to a specific identified responsive behaviour that was documented as occurring on seven occasions; furthermore, the plan of care did not provide interventions giving direction to staff on how to manage this responsive behaviour.

In an interview with Personal Support Worker (PSW) #106, they identified that resident #001 had exhibited the identified responsive behaviour and would still be observed as exhibiting on occasions. PSW #106 verified that staff were to complete a specific intervention in order to cease the identified responsive behaviour and report what they observed to the registered staff. PSW #106 confirmed that staff would locate this information by reviewing the resident's care plan.

In an interview with Registered Practical Nurse (RPN) #102, they indicated that resident #001 began to demonstrate the identified responsive behaviour during a specific time period. RPN #102 confirmed that the identified responsive behaviour was to be added to resident #001's care plan and that it was not present in their care plan.

During an interview with Registered Nurse (RN) #110, they indicated that a resident's care plan was to be reviewed and revised when a resident was exhibiting a change with their responsive behaviours by identifying the behaviour and the interventions staff were

to complete in response to the behaviour. RN #110 verified that resident #001 was observed to be exhibiting the identified responsive behaviour and that staff were to complete a specific intervention and report the behaviour to the registered staff. RN #110 confirmed that resident #001's care plan had not been revised with the identified responsive behaviour and that it should have been.

Together, Inspector#692 and the Director of Care (DOC) reviewed resident #001's most recent care plan. The DOC identified that the care plan for resident #001 had not been revised to reflect the current responsive behaviours the resident was exhibiting and did not have current interventions. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.