Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Aug 20, 2019	2019_668543_0016	013759-19	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

TIFFANY BOUCHER (543)

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): August 12 and 13, 2019.

A complaint submitted to the Directror, related to falls, was inspected during this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Personal Support Worker (PSW) and family members of residents.

The Inspector(s) also conducted daily tours of the resident care areas, observed the provision of care towards residents and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A complaint was submitted to the Director on a date in July, 2019, related to a fall that occurred in April 2019, with resident #001 that resulted in an injury.

Inspector #543 reviewed resident #001’s health care record which identified that on a date in April, 2019, the resident fell and sustained an injury. The resident was transferred to hospital for assessment.

Inspector #543 reviewed the resident’s most recent care plan which identified that resident #001 was at a specific risk for falls, related to not using their specific assistive device at all times. The resident's care plan indicated that staff would encourage the resident to use the assistive device properly, to return the assistive device to the resident if it was not within reach and to provide education on the importance of using the specific device at all times for safety.

Inspector #543 observed the resident on August 12 and 13, 2019, and did not observe the resident using a specific assistive device for mobility.

Inspector #543 interviewed PSW #100 who indicated that resident #001 no longer used the specific assistive device for mobility.

Inspector #543 interviewed RN #101 who verified that the resident no longer used the specific assistive device for mobility.

The Inspector interviewed the Director of Care, who verified that the resident no longer utilized the specific assistive device for mobility. [s. 6. (10) (b)]

Issued on this 21st day of August, 2019

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

Original report signed by the inspector.