

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
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
Sep 15, 2021	2021_864627_0021	010056-21	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

SYLVIE BYRNES (627)

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 30-31, September 1-3, 2021.

One intake, related to alleged staff to resident abuse, was inspected during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Service/Maintenance worker, Housekeepers, residents and their families.

The Inspector conducted daily observations of the provision of care to the residents, staff to resident interactions, observed infection prevention and control (IPAC) practices, cooling and air temperature requirements, reviewed relevant health care records, relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home**

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

3 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was protected from abuse by a staff member.

A complaint was submitted to the Director alleging abuse from a staff member, towards a resident.

Staff reported that a particular staff member's actions toward the resident were abusive and that their actions negatively impacted the resident.

The Admin/DOC stated that the actions taken by the staff member were never acceptable.

Sources: Interviews with complainant, PSWs, RPNs, RN, Admin/DOC; record review, resident's care plan, home's policy titled, "Abuse- Prevention and Elimination of Abuse and Neglect.

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 residents are protected from abuse by anyone, 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 staff participated in the implementation of the Infection Prevention and Control (IPAC) program, related to hand hygiene.

The licensee's IPAC program required staff to ensure that residents were encouraged or assisted with hand hygiene before and after meals, after using the washroom, before and after using shared activity equipment, and when leaving or returning to their room.

During observations of three meal services, residents were not encouraged or assisted with performing hand hygiene prior to being served their meal and after they finished their meal. Staff members reported that residents were assisted with hand washing in their rooms or in the dining room, with a disinfectant wipe, if their hands were visibly soiled. The independent residents were expected to wash their hands before and after meals independently and that it was "a hit or miss". The Administrator/Director of Care (Admin/DOC) stated that the home's expectation was that residents' hands be washed before and after meals, snacks and activities, when the residents go to the dining room, after going to the washroom and anytime that hands were visibly soiled.

There was actual risk to residents for the lack of the implementation of the home's hand hygiene program.

Sources: Observation of two lunch meal services and one supper meal service. Interviews with PSWs, RPN, Admin/DOC; record review of home's IPAC policy titled, "Hand Hygiene".

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 program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

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1. The licensee has failed to ensure the air temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

As per the amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements, which was sent April 1, 2021, with an effective date of May 15, 2021, Long-Term Care Home's were required to measure and document the air temperature, at a minimum, in the following areas of the home three times per day:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor; and
3. For LTCHs that are not centrally air-conditioned, every designated cooling area, if there are any in the home.

LTCHs are required to keep a record of these documented measurements for at least one year.

The Inspector reviewed the "Internal temperature log" for a 30 day period, and noted that there was no documentation for 19 of the 30 days. The Environmental Service/Maintenance staff member outlined that air temperature was monitored daily when the temperature outside was predicted to be 25 degrees Celsius or higher. The staff member identified they weren't aware of the changes and they had not obtained readings in all of the required areas when the daily temperature was predicted to be less than 25 degrees Celsius.

The home's failure to ensure that air temperatures were monitored at least three times per day presented minimal risk to residents.

Sources: memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Internal temperature log, interviews with an Environment service/maintenance staff member. [s. 21. (3)]

Issued on this 16th day of September, 2021

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

Original report signed by the inspector.