Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 12, 13, Dec 6, 7, 8, 13, 2011	2011_056158_0013	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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the RAI Co-ordinator, the Food Service Supervisor, the Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and several residents.

During the course of the inspection, the inspector(s) observed lunch and snack service, reviewed several residents' health care records, and observed staff interaction and care with residents.

The following Inspection Protocols were used during this inspection:

Dining Observation

Nutrition and Hydration

Snack Observation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. A resident's plan of care identified the resident was at high risk to choke and aspirate. The resident was observed by the inspector to drink a thickened supplement with no supervision at 1445 on Oct. 12/11. The resident was heard to be gurgling.
The resident's plan of care identified that the resident is to be provided with "supervision for all meals and snacks".
The licensee did not ensure that the care set out in the resident's plan of care was provided as specified in the plan.
[LTCHA 2007, S.O. 2007, c. 8, s. 6(7)]
2. A resident's plan of care located on the computer identified that the resident is a "moderate nutritional risk and may not be consuming enough fluids. Weight is to be monitored and thickened fluids are to be given at meals". The resident's specific diet and textures were also identified. The resident's plan of care identified that an adaptive aid is to be used at lunch and dinner. The printed plan of care which is accessible to the staff who provide the resident's direct care did not identify the adaptive aid.
Clear direction was not set out in the resident's written plan of care for staff and others who provide direct care.
[LTCHA 2007, S.O. 2007, c. 8, s. 6(1)(c)]
3. A resident was assessed by the dietitian as requiring a specific textured diet with thickened fluids. The resident's printed plan of care which is accessible to the staff who provide the direct care identified a different textured diet under nutrition, as well as the resident's assessed diet. The Sept. 18/11 nourishment list identified a totally different diet than what was assessed by the dietitian.
Clear direction was not set out in the resident's written plan of care for staff and others who provide direct care to the resident.
[LTCHA 2007, S.O. 2007, c. 8, s. 6(1)(c)]
4. The dietitian assessed a resident a "moderate" nutritional risk. Interventions such as "help/supervision with eating, ensure the resident sits up to reduce choking" were also identified.
The resident's printed plan of care, which is accessible to the staff who provide direct care was reviewed by the inspector on Oct 12/11. A level of assistance with eating was not documented, nor were interventions to reduce choking episodes.
Clear direction was not set out in the resident's written plan of care for staff and others who provide direct care.
[LTCHA 2007, S.O. 2007, c. 8, s. 6(1)(c)]
5. A resident's plan of care was reviewed by the inspector on Oct 12/11. The dietitian's assessment identified that the resident was a high nutritional risk. It also identified the resident has a moderate risk of dehydration related to poor fluid intake. The resident's printed plan of care, which is accessible to the staff who provide direct care identified that the resident requires only the " assistance with the set up of meals". The plan of care did not include interventions related to the supervision for choking episodes.
The resident's plan of care does not set out clear direction for the staff and others who provide direct care.
[LTCHA 2007, S.O. 2007, c. 8, s. 6(1)(c)]

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 ensuring that all residents' plans of care which are accessible to staff who provide direct care sets out clear directions to staff and other who provide direct care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee did not ensure that each resident is offered a between-meal beverage in the afternoon.
The 1400h nourishment pass delivered by a PSW was observed by the inspector on Oct 12/11 and the following observations were made:
One resident was to receive a dietary supplement at 1400h, however, the supplement was not offered or provided to the resident. The PSW had reported to the inspector that the resident was sleeping, however, the resident was easily roused by the inspector. The resident's nutritional intake record identified that the resident had refused this intake. The resident's nutritional intake record also identified that the resident had refused fluids every day since Oct. 3/11.
[O. Reg. 79/10, s. 71 (3)(b)]
A second resident was observed by the inspector to be sleeping. The PSW identified to the inspector that the resident was not offered or given fluids as the resident was sleeping. This resident's nutritional intake record identified that the resident had refused fluids every day since Oct. 3/11.
[O. Reg. 79/10, s. 71 (3)(b)]
A third resident was observed by the inspector to be sleeping. The PSW identified to the inspector that the resident was not offered fluids as the resident was sleeping. This resident's nutritional intake record identified that the resident had refused fluids every day since Oct. 3/11.
The PSW confirmed on Oct 12/11 that residents who are sleeping are not awakened for the 1400h nourishment pass.
[O Reg 79/10, s. 71(3)(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 ensuring all residents are offered a between-meal beverage in the afternoon in accordance with care needs and preferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The home did not ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission into the home.
A resident was recently admitted to the home.
A 24-hour "Plan of Care form" was found on the resident's health care record, however, this was blank except for the resident's admission information and diagnosis. The resident's plan of care on the computer had no information in it.
A written plan of care for this resident was not found by the inspector. It was confirmed by the DOC on Oct 13/11 that the 24-hr plan of care was not completed.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there is a process in place during the nourishment pass for the staff to be aware of residents' diets, special needs and preferences.
The nourishment pass was observed by the inspector on Oct. 12/11 at 1400.
The PSW was not observed by the inspector to use the nourishment list, which identifies the residents' nutritional needs during the nourishment pass.
One resident on the list had been discharged from the home.
Another resident on the list was deceased.
This nourishment list was dated Sept.18/11. It was confirmed by the Food Service Supervisor on Oct. 12/11 that the list was outdated.
Puree items such as apple sauce, ice cream or puddings were not available on the cart for the Oct 12/11 nourishment pass at 1400.
12 jugs of water were not delivered to the residents whose request was identified on a separate list found on the nourishment cart.
[O Reg 79/10, s. 73(1) 5]

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 ensuring that the staff assisting with the nutritional pass use and follow the current nutritional list, to be implemented voluntarily.

Issued on this 4th day of January, 2012

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

Ontario

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Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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Oct 12-13/11	2011_056158_0013	Follow-up

Licensee/Titulaire de permis
675412 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/Nom de l'inspecteur ou des inspecteurs
Kelly-Jean Schienbein (158)

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O. Reg. 79/10, s.26 (4((a)(b)	CO-001	2011_163_2585_31May10491 2	163

Issued on this 10th day of December, 2011

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

K Schienbein