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 le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2018;	2017_669642_0017 (A1)	022206-17	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

AMY GEAUVREAU (642) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The findings to WN #1 have been amended to reflect the correct compliance of sections related to the previous compliance order.

Issued on this 16 day of January 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

AMY GEAUVREAU (642) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 16-20, 2017

Additional Logs inspected concurrently during this Resident Quality inspection (RQI) included:

One complaint submitted to the Director, related to unknown injuries of a resident of unknown cause.

Two Compliance Orders (CO's);

CO #001, s. 19, related to duty to protect,

CO #002, r. 69, was related to weight changes.

Five CO's;

CO #001, s. 6 (1), related to plan of care and clear direction,

CO #002, s. 6 (2), related to plan of care, assessment, care needs, and preferences,

CO #003, s. 31 (2), related to restraint orders,

CO #004, s. 8 (1), is related to complying with policy, and

CO #005, s. 110 (2), is related to restraints and reassessing.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Director of Therapeutic Recreation Services, Food Service Nutritional Manager, (FSNM), Pharmacist, Registered Dietitian (RD), Registered Nurses (RNs) Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Health Care Aids (HCAs), residents, and family members.

During the course of the inspection, the Inspector(s) directly observed the delivery of resident care, staff to resident interactions, resident to resident interactions, conducted a daily tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures and programs and reviewed staff education records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Skin and Wound Care

Training and Orientation

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

- **9 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **1 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. 110. (2)	CO #005	2017_633577_0009	642
LTCHA, 2007 s. 19. (1)	CO #001	2017_633577_0008	609
LTCHA, 2007 s. 31. (2)	CO #003	2017_633577_0009	642
LTCHA, 2007 s. 6. (1)	CO #001	2017_633577_0009	609 642
LTCHA, 2007 s. 6. (2)	CO #002	2017_633577_0009	609 642

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. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

-A change of 5 per cent of body weight, or more, over one month;
-A change of 7.5 per cent of body weight, or more, over three months;
-A change of 10 per cent of body weight, or more, over 6 months; and
-Any other weight change that compromises the resident’s health status.

A previous Compliance Order (CO) #002 was issued to the home, to address the licensee's failure to comply with s. 69 of O.Reg. 79/10 during an Complaint Inspection. Full compliance of the CO was expected by June 9, 2017.

The CO required the licensee to prepare, submit and implement a plan to:

a) Educate all staff who provide direct care to the residents on the home's written policy "Weighing Residents" and ensure that the policy was complied with;
b) Ensure that the PSW's were communicating weight changes to the registered staff; and,
c) Ensure that the registered staff were completing referrals to the Registered Dietitian when there was a significant weight change.

While the licensee had complied sections "a and b", section, "c", where the licensee was ordered to ensure that registered staff were completing referrals to the Registered Dietician when there were significant weight changes, was not complied with. Additional non-compliance related to this regulation was also identified.

1) Inspector #609 reviewed the education required by the home to be provided to staff related to weight changes. The education outlined how Health Care Aids (HCA's) were to immediately report weight variances to the registered staff and if the weight change was verified as significant, registered staff were to complete an Registered Dietitian (RD) referral.

A review of the staff list indicated that HCA #102 and RPN #108 had signed that they had completed the weight education.

During an interview with HCA #102, they indicated that weights were recorded in the weight binder and that registered staff were to review the binder. The HCA failed to indicate that they would notify registered staff immediately of any resident with a significant weight change.

During an interview with RPN #108, they indicated that only the resident's Medical Doctor (MD) was able to make a referral to the RD and that if a resident was to be identified with a significant weight change this information would be documented in the MD communication binder.

2) Resident #006 was identified as having weight change since admission, from their record review.

A review of resident #006's health care records by Inspector #609, found that the resident had a weight change over the previous three months.

A further review of resident #006's health care records showed a weight change greater than 10 per cent from one month to the next month and during two separate occasions spanning a period of six months.

A review of the home's policy titled "Role of Dietitian- CD-07-15" dated June, 2010, indicated that the RD was to complete documentation on resident's records, including progress notes, interventions and outcomes.

A further review of resident #006's health care records found no accompanying assessments or progress notes from the RD to indicate that the resident's three months of significant weight changes were evaluated or any actions taken, until two weeks after the third consecutive month of weight changes were identified.

During an interview with the Administrator, they explained that the RD referrals were completed by registered staff on a paper tool which is then collected by the RD when they were next in the home.

Inspector #609 interviewed the RD, who stated that they track the significant weight changes on an exception report and if an intervention is needed they would then intervene, therefore no referral is needed to intervene.

A review of the home's policy titled, "Weighing Residents- CN-W-02," dated May,

2016 indicated that if a change in weight was confirmed as significant, that a RD referral was to be completed.

Inspector #609 reviewed resident #006's health care records, and the RD folder and found no referral was generated for the resident's three consecutive months of significant weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Compliance Order (CO) #004 was issued with a compliance due date of June 15, 2017. The licensee was ordered to review and re-educate all staff and others who provided direct care to the residents on the home's written policies.

a) "Fall Prevention and Management",
b) "Hydration Management",
c) "Pain Management", and
d) "Documentation-HCA/PSW Resident Care Flow Sheet".
The home was to maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

While the licensee had complied with sections, "b and d", section "a and c", where the licensee was ordered to re-educate all staff and maintain a record of retraining, what the training entailed, who completed the training and when the training was completed, was not complied with.

Inspector #642 reviewed the documentation provided from the Administrator from the "Surge on Line Learning System," to ensure all staff completed the required training.

1) The documentation provided revealed that from the "Surge Learning System: Module 1 The Pain Experience: A Module for Direct Care Staff by Surge Learning," 40.5% of the PSW's had not completed the retraining.
2) The Falls documentation from Surge Learning titled "Falls Prevention Part 1: An Introduction by Surge Learning Inc. for 2017," stated that 25% of the PSW's had not completed the retraining.
3) The document titled "Falls Prevention Part 2: Falls Risk Factors in Seniors by Surge Learning Inc. for 2017," stated that 25% of the PSW's had not completed the retraining.
4) The document titled "Falls Prevention Part 3: Assessment and Interdisciplinary Roles by Surge Learning Inc. for 2017", revealed that 27.8% of the PSW's had not completed the retraining.

Inspector #642 interviewed the Administrator, who stated that the PSW's did all their retraining on the Surge Learning Training for the Fall Prevention and Management, and Pain Management policies and there was no other retraining provided for the PSW's.

During staff interview's with PSW #111 and PSW #112, they reported that they had

not completed the retraining on the Surge Learning Training web site, for the Fall Prevention and Management, and Pain Management Policies.

Inspector #642 interviewed the Administrator, and they stated that the retraining for the Pain and Fall Management policies should have been completed by a specific date as required by CO #004. The Administrator stated the education completed on the Surge Learning were the correct percentage of PSW's who had not completed the education for the Pain Management and Falls Prevention program policies. The Administrator stated that the education for the Pain Management and Falls Prevention program had not been fully completed at this time for all the PSW's. [s. 8. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During an interview, resident #001 reported to Inspector #681 that they had been treated rudely and had been yelled at by a staff member. Resident #001 stated that they rang the call bell and had requested an item and when RN #104 responded to the call bell, they yelled at them in a belittling manner. Resident #001 reported that RN #104 then slammed the door and did not get them the item requested. Resident #001 also advised Inspector #681 that they told the Administrator/DOC about this concern.

In an interview with Inspector #681, resident #001 stated that the incident was still fresh in their memory and that the incident made them cry.

Inspector #681 reviewed the home’s policy titled, "Abuse – Prevention, Reporting, and Elimination of Abuse and Neglect," dated May 2016. The policy stated that residents will be protected by abuse by anyone. Examples of verbal abuse provided in the policy includes “inappropriate tone of voice and manner of speaking”.

In an interview with Inspector #681, RN #104 acknowledged that they spoke “harshly” to resident #001.

Inspector #681 reviewed RN #104’s employee file, which included disciplinary action related to the incident with resident #001. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the quarterly review of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review.

Inspector #609 requested of the Administrator, the written record of the quarterly review of all medication incidents. In a subsequent interview the Administrator stated that the quarterly medication incident reviews were conducted but that a record of the reviews were not kept and should have been.

A review of the home's policy titled, "Drug and Therapeutics Committee- CA-03-04," dated June 2010, outlined that the drug utilization trends and patterns as well as any medication incidents and adverse drug reactions were to be reviewed quarterly. The policy failed to indicate that a record of the quarterly review was to be kept. [s. 135. (3)]

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 the quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. The licensee shall keep a written record of any changes identified in the review, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident had been given the opportunity to participate fully in the development and implementation of the plan of care.

Inspector #609 interviewed resident #005, who indicated that staff would refuse to allow them to take part in a certain activity. Staff would also refuse to provide the resident the item they requested if they did not complete a different activity. The resident further indicated that they had told staff that they did not want this practice to continue and felt they were being punished.

A review of resident #005's current plan of care directed staff, that as per family, the resident was not allowed to take part in a certain activity unless they completed a different activity.

During an interview with HCA #101, they verified that resident #005's family desired the resident to complete a certain activity and that registered staff would refuse to allow the resident to take part in another activity until the first activity was completed.

During an interview with RPN #100, they verified that resident #005 was capable of making their own decisions and that when the resident did not complete a certain activity they would refuse to allow the resident to take part in the other activity.

A review of the home's policy titled "Residents' Bill of Rights- CA-02-11" dated May 2010 indicated that every resident had the right to have his or her participation in decision-making respected.

During an interview with the Administrator, they verified that resident #005 was capable of making their own decisions and that there was no enacted power of attorney or substitute decision-maker for the resident. The Administrator also verified that they had been aware for the past two weeks of the resident's decision to do a certain activity and that they did not want the second activity withheld. The resident should have been provided the right to participate fully in the development and implementation of their plan of care. [s. 6. (5)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings
Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so.

Inspectors #609 and #681 observed that eight out of the 20 sampled residents did not have a personal, easy chair in their room.

In an interview with Inspector #681, resident #001 stated that they were hoping to get another chair for their room so that they could watch television with their roommate without one of them having to sit on the bed. Resident #003 also advised Inspector #681 that they were initially bothered by the fact that there was not a chair in their room and that they were told by the home that there was not enough space for chairs in their room.

Inspector #681 reviewed the home's admission package document titled, "Conmed Health Care Group – Welcome Home," which indicated that a comfortable side chair with arms would be included at no additional charge.

During an interview with Inspector #681, the Director of Therapeutic and Recreation Services stated that the homes tries to ensure that everyone has their own chair so that residents have a place to sit other than their bed. However, space is sometimes an issue, especially if a resident wants to bring in a large chair.

During an interview with Inspector #681, the Administrator/DOC stated that the home counted all the chairs in the facility and that there are enough chairs for all residents and that they can bring up extra chairs from the basement if necessary. The Administrator/DOC stated that at the time of the count, any resident who wanted a chair was provided with one and that some residents or families prefer to have their own chairs put into the activity room where they can be more social. The Administrator/DOC stated that they understood that is it part of the legislation that every resident may have a chair in their room. [s. 12. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident had occurred by the licensee or staff had, immediately reported the suspicion and the information upon which it was based, to the Director.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Resident #001 reported to Inspector #681 that they had been treated rudely and yelled at by a staff member. Please refer to WN #3 for further details.

During an interview with Inspector #681, the Administrator/DOC stated that they were aware of this complaint from resident #001 and that the home immediately investigated the incident as an allegation of verbal abuse. As a result of the home's investigation RN #104, was provided with a disciplinary action related to this incident. However, the Administrator/DOC stated that a critical incident report was not submitted to the Director related to this allegation of staff to resident abuse. [s. 24. (1)]

WN #8: 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 each resident who was incontinent received an assessment that included 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #001 was identified as being incontinent through a Minimum Data Set (MDS) assessment, from their Admission to 90-day assessments.

During an interview with Inspector #681, PSW #109 stated that resident #001 was incontinent and that they used a certain number of a specific incontinent product per day. PSW #109 stated that resident #001 previously used a different product, but was recently switched because of not offering sufficient protection.

Inspector #681 reviewed the staff communication binder located at the nursing station. Included in the communication binder was a note written by the Administrator/DOC, which stated to increase the number of the certain incontinent product for resident #001 per day.

Inspector #681 reviewed resident #001's electronic medical record. Resident # 001's electronic medical record did not include a recent continence assessment.

During an interview with Inspector #681, RN #106 stated that the home completes a, "Admission Bowel and Bladder assessment" in Point Click Care when a resident is admitted to the home, and whenever there is a significant change in continence

status. RN #106 stated that resident #001 recently switched from one continent product to another and their usage had increased. RN #106 verified that a continence assessment had not been completed for resident #001 and that a change in the type or increase in the number of continence products being used would be considered a significant change that would warrant an assessment.

Inspector #681 reviewed the home's policy titled "Continence Care and Bowel Management Program" last revised April 18, 2016. The policy indicated that each resident will be assessed within seven days of admission, at least quarterly and with any change in health status that affects continence, using the MDS assessment initially. If further assessment is required, then the continence assessment tool will be completed.

Inspector interviewed the Administrator/DOC, who stated that the, "Admission Bowel and Bladder Assessment" in PCC is completed on admission, and whenever there is a significant change in continence. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #609 observed RN #106 administer a medication to resident #013.

A review of resident #013's medication order indicated that this resident was to receive an injection which was to be administered to the resident daily at a specific time.

A review of a specific home policy provided direction on how to prepare and administer the specific medication injection.

The Inspector observed RN #106 preparing the medication for resident #013. The RN did not follow the proper preparation and administration of the specific medication as described in the policy.

During an interview with the home's Pharmacist, they verified the proper preparation and administration of the medication as described in the policy.

During an interview with the Administrator, they verified that RN #106 should have prepared and administered the medication as described in the policy. [s. 131. (2)]

Issued on this 16 day of January 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMY GEAUVREAU (642) - (A1)

Inspection No. / No de l'inspection : 2017_669642_0017 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 022206-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 16, 2018;(A1)

Licensee / Titulaire de permis : 675412 Ontario Inc.
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

LTC Home / Foyer de SLD : NORTHVIEW NURSING HOME
77 RIVER ROAD, P.O. BOX 1139, ENGLEHART, ON, P0J-1H0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tracey Gemmill

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To 675412 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_633577_0008, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The Licensee shall prepare, submit and implement a plan that ensures residents with weight changes as identified in O.Reg. 79/10 are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

This plan shall include but not be limited to addressing the following:
a) ensuring registered staff complete referrals to the registered Dietitian when the identified weight changes have occurred and that this referral is documented and remains with the resident's file, and;
b) ensure all interdisciplinary staff document actions and outcomes after evaluations are completed.

This plan shall be submitted to Amy Geauvreau, Long-Term Care Homes Inspector at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133 or emailed to SudburySAO.moh@ontario.ca.

This plan must be submitted by January 12, 2017 and fully implemented by February 9, 2018.

Grounds / Motifs :

(A1)
1. 1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

-A change of 5 per cent of body weight, or more, over one month;
-A change of 7.5 per cent of body weight, or more, over three months;
-A change of 10 per cent of body weight, or more, over 6 months; and
-Any other weight change that compromises the resident's health status.

A previous Compliance Order (CO) #002 was issued to the home, to address the licensee's failure to comply with s. 69 of O.Reg. 79/10 during an Complaint Inspection. Full compliance of the CO was expected by June 9, 2017.

The CO required the licensee to prepare, submit and implement a plan to:

a) Educate all staff who provide direct care to the residents on the home's written

policy "Weighing Residents" and ensure that the policy was complied with;
b) Ensure that the PSW's were communicating weight changes to the registered staff; and,
c) Ensure that the registered staff were completing referrals to the Registered Dietitian when there was a significant weight change.

While the licensee had complied sections "a and b", section, "c", where the licensee was ordered to ensure that registered staff were completing referrals to the Registered Dietician when there were significant weight changes, was not complied with. Additional non-compliance related to this regulation was also identified.

1) Inspector #609 reviewed the education required by the home to be provided to staff related to weight changes. The education outlined how Health Care Aids (HCA's) were to immediately report weight variances to the registered staff and if the weight change was verified as significant, registered staff were to complete an Registered Dietitian (RD) referral.

A review of the staff list indicated that HCA #102 and RPN #108 had signed that they had completed the weight education.

During an interview with HCA #102, they indicated that weights were recorded in the weight binder and that registered staff were to review the binder. The HCA failed to indicate that they would notify registered staff immediately of any resident with a significant weight change.

During an interview with RPN #108, they indicated that only the resident's Medical Doctor (MD) was able to make a referral to the RD and that if a resident was to be identified with a significant weight change this information would be documented in the MD communication binder.

2) Resident #006 was identified as having weight change since admission, from their record review.

A review of resident #006's health care records by Inspector #609, found that the resident had a weight change over the previous three months.

A further review of resident #006's health care records showed a weight change greater than 10 per cent from one month to the next month and during two separate

occasions spanning a period of six months.

A review of the home's policy titled "Role of Dietitian- CD-07-15" dated June, 2010, indicated that the RD was to complete documentation on resident's records, including progress notes, interventions and outcomes.

A further review of resident #006's health care records found no accompanying assessments or progress notes from the RD to indicate that the resident's three months of significant weight changes were evaluated or any actions taken, until two weeks after the third consecutive month of weight changes were identified.

During an interview with the Administrator, they explained that the RD referrals were completed by registered staff on a paper tool which is then collected by the RD when they were next in the home.

Inspector #609 interviewed the RD, who stated that they track the significant weight changes on an exception report and if an intervention is needed they would then intervene, therefore no referral is needed to intervene.

A review of the home's policy titled, "Weighing Residents- CN-W-02," dated May, 2016 indicated that if a change in weight was confirmed as significant, that a RD referral was to be completed.

Inspector #609 reviewed resident #006's health care records, and the RD folder and found no referral was generated for the resident's three consecutive months of significant weight changes.

The decision to issue this compliance order was based on the scope of being isolated, the severity, which was determined to be minimal harm or potential for actual harm, and the compliance history, which despite previous non-compliance's issued, including one Compliance Order (CO), issued during inspection #2017_633577_0008, a Voluntary Plan of Correction (VPC) issued during inspection #2016_391603_0019, and a Written Notification (WN) was issued from inspection #2015_380593_0018, non-compliance continues with this section of the legislation. (609)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Feb 09, 2018

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2017_633577_0009, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The Licensee shall review and re-educate all remaining Personal Support Workers/Health Care Aids who had not completed the training as identified from this inspection on the home's written policies, specifically:
a) "Fall Prevention and Management," and,
b) "Pain Management."
The home are to maintain a record of retraining, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Compliance Order (CO) #004 was issued during with a compliance due date of June 15, 2017. The licensee was ordered to review and re-educate all staff and others who provided direct care to the residents on the home's written policies;

a) "Fall Prevention and Management",
b) "Hydration Management",
c) "Pain Management", and
d) "Documentation-HCA/PSW Resident Care Flow Sheet".
The home were to maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

While the licensee had complied with sections, "b and d", section, "a and c", where the licensee was ordered to re-educate all staff and maintain a record of retraining, what the training entailed, who completed the training and when the training was completed was not complied with.

Inspector #642 reviewed the documentation provided from the Administrator from the "Surge on Line Learning System," to ensure all staff completed the required training.

1) The documentation provided revealed that from the "Surge Learning System: Module 1 The Pain Experience: A Module for Direct Care Staff by Surge Learning." stated that 40.5% of the PSW's had not completed the retraining.
2) The Falls documentation from Surge Learning titled "Falls Prevention Part 1: An Introduction by Surge Learning Inc. for 2017," stated that 25% of the PSW's had not completed the retraining at this time.
3) The document titled "Falls Prevention Part 2: Falls Risk Factors in Seniors by Surge Learning Inc. for 2017," stated that 25% of the PSW's had not completed the retraining.
4) The document titled "Falls Prevention Part 3: Assessment and Interdisciplinary Roles by Surge Learning Inc. for 2017", revealed that 27.8% of the PSW's had not completed the retraining.

Inspector #642 interviewed the Administrator, who stated that the PSW's did all their retraining on the Surge Learning Training for the Fall Prevention and Management, and Pain Management policies and there was no other retraining provided for the

PSW's.

During a staff interview with PSW #111, and PSW #112, they reported that they had not completed the retraining on the Surge Learning Training web site for the Fall Prevention and Management, and Pain Management Policies.

Inspector #642 interviewed the Administrator, and they stated that the retraining for the Pain and Fall Management policies should have been completed by a specific date as required by CO #004. The Administrator stated the education completed on the Surge Learning were the correct percentage of PSW's who had not completed the education for the Pain Management and Falls Prevention program policies. The Administrator stated that the education for the Pain Management and Falls Prevention program had not been fully completed at this time for all the PSW's.

The decision to issue this compliance order was based on the scope which was determined to be isolated, the severity, which was determined to be minimal harm with potential for actual harm, and the compliance history, which despite previous non-compliance issued, including a Compliance Order (CO), issued during inspection #2017_633577_0009, a CO issued during inspection #2016_391603_0019, and a Written Notification issued during inspection, #2014_336580_0025, non-compliance continues with this section of the legislation. (642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Feb 09, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMY GEAUVREAU - (A1)

Ontario

Ministry of Health and Long-Term Care

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Service Area Office / Bureau régional de services : Sudbury