Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Modified Public Report (M)

Report Issue Date September 7, 2022
Inspection Number 2022_1099_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
675412 Ontario Inc.

Long-Term Care Home and City
Northview Nursing Home, Englehart

Inspector who Amended
Karen Hill #704609

Inspector who Amended Digital Signature
Karen L Hill
Digitally signed by Karen L Hill
Date: 2022.09.07 11:41:34 -04'00'

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect a new inspection number. The Complaint inspection, #2022_1099_0001 was completed on August 10-12, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 10-12, 2022.

The following intake(s) were inspected:

- One intake of a complaint related to an allegation of unsafe transfers.

The following **Inspection Protocols** were used during this inspection:
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: FLTCA, 2021 s. 6. (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident, that provided clear directions to staff and others who provided direct care to the resident.

Rationale and Summary:
A resident was transferred using a specific transfer device with specific staff assistance.

Signage, indicating that staff were to use the specific transfer device, was posted in the resident's room. The resident's health record also indicated that they required a specific transfer status. The resident's care plan, however, did not include information about the specified transfer device or requirements for staff assistance.

The resident, and a registered nursing staff member, both confirmed that the resident required the specified transfer device and specific staff assistance. The registered nursing staff member acknowledged that the resident's care plan did not include their transfer status; that it must have been overlooked, and immediately updated the care plan to include direction on the resident's transfer requirements.

There was minimal impact and low risk to the resident, at the time of the non-compliance, when the home did not ensure that the written plan of care provided clear direction to staff and others providing care to the resident.

Sources: Observation of a resident; a resident's health records; and interviews with the resident and a registered nursing staff member.

Date Remedy Implemented: August 11, 2022 [704609]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 23 (2) (a)

The licensee has failed to ensure that the infection prevention and control program included evidence-based policies and procedures.

Rationale and Summary:
At the time of the inspection, the home was unable to provide copies of specific IPAC policies or procedures.

The IPAC Lead and Resource Nurse both acknowledged that the home did not have the identified IPAC policies and procedures in place and should have.

There was minimal impact and possible risk to residents of being exposed to inadequate infection prevention and control practices, when the licensee failed to ensure that the home had IPAC policies and procedures in place in accordance with evidence-based practices.

Sources: Review of licensee's IPAC program policies; and interviews with the IPAC Lead and Resource Nurse.

[704609]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

The licensee failed to ensure that staff roles and responsibilities were clearly defined and communicated regularly to all staff, related to the implementation and ongoing delivery of the IPAC program.

Specifically, the licensee did not ensure that written records were kept of the staff roles, responsibilities, and accountabilities, related to the implementation and ongoing delivery of the IPAC program, in a readable and useable format, that allowed a complete copy of the record to be readily produced, as is required by Additional Requirement 1.2 under the IPAC Standard, April 2022.

Rationale and Summary:
At the time of the inspection, the home was unable to provide a copy of the IPAC Lead job description.

The IPAC Lead and Resource Nurse verified that the home did not have a job description in place for the IPAC position.

There was minimal risk and impact at the time of the non-compliance when the home failed to keep a written record outlining staff roles and responsibilities related to the implementation and ongoing delivery of the IPAC program.

Sources: Review of licensee's IPAC program policies; IPAC Standard for Long-Term Care Homes, April 2022; and interviews with the IPAC Lead and Resource Nurse.

[704609]

WRITTEN NOTIFICATION [TRANSFERRING AND POSITIONING TECHNIQUES]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that direct care staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary

A resident's plan of care indicated that their transfer status required staff to use a specified transfer device, with specific staff assistance.

During the inspection, a staff member was observed using the specified transfer device without the specific staff assistance.

The resident and two staff members, all indicated, that prior to this incident, the specified transfer device had been used to transfer the resident, without the proper staff assistance.

The licensee's policy titled, "Safe Resident Handling", indicated that staff were to adhere to the designated lift/transfer status as identified on each resident's care plan. Further to this, use of the specified transfer device required specific staff assistance.

Staff members, the Physiotherapist (PT), and the Resource Nurse, all verified that staff were always required to follow the resident's plan of care specific to lifts and transferring; that not doing so posed a safety risk to the resident and would not be complying with what was required by the home.

There was minimal impact and moderate risk to the resident, when the home did not ensure that all direct care staff used safe transferring and positioning techniques when assisting the resident.

Sources: Observations; a resident's health record; the licensee's policy titled, "Safe Resident Handling (SRH) - Back to Basics", last revised January 2021; and interviews with a resident, a PT, the Resource Nurse, and other staff.

[704609]

WRITTEN NOTIFICATION [ORIENTATION]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 259 (1) 2.

The licensee has failed to ensure that during orientation, training was provided related to safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids, and positioning aids, relevant to the staff member's responsibilities.

Rationale and Summary
At the time of the inspection, the home was unable to locate evidence of training, for certain staff members working in the home, related to the safe and correct use of equipment when performing resident lifts and transfers,

A review of the safe resident handling course, assigned to those staff members, revealed they had not completed the training assigned during orientation.

A manager and the Resource Nurse, both verified safe resident handling training was required to be completed during orientation, by all direct care staff. They acknowledged that upon investigation, the staff members had not in fact completed the training assigned to them, during their orientation.

Failure of the home to ensure that staff completed training in safe and correct use of equipment, in accordance with the regulations, may have put residents in the home at risk for unsafe transfers and positioning.

Sources: Review of facility training records and orientation checklists; the licensee's policy titled, "Safe Resident Handling; direct care staff schedules; and interviews with a manager, the Resource Nurse and other staff.

[704609]