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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 2, 2015	2015_30610a_0015	H-003263-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

Long-Term Care Home/Foyer de soins de longue durée

NORTHLAND POINTE
2 Fielden Avenue PORT COLBORNE ON L3K 6G4

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

IRENE SCHMIDT (510a), BARBARA NAYKALYK-HUNT (146)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 23, 24, 25, 28, 29, 30, October 1, 6, 7 and 8, 2015

During this RQI, four follow up orders were complied: log #008098-15 (H-000149-13), log #008099-15 (H-001593-14), log #008104-15 (H-001594-14) and log #008109-15 (H-001595-15). In addition, four complaints, log #008291-14 (H-001624-14, log #003042-15 (H-002052-15), log #007052-15 (H-002355-15), log #023270-15 (H-003171-15) and 2 CI's Log #01055-14 (H-001781-14), log #000783-15 (H-001862-15), were inspected.

During the course of the inspection, the inspector(s) spoke with residents, family members, Administrator, Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), personal support workers (PSW), registered nurses (RN), registered practical nurses (RPN), registered dietician (RD), MDS coordinator, manager of recreation, dietary staff, housekeeping staff, and facility/maintenance staff.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
3 VPC(s)
0 CO(s)
0 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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2014_306510_0019	146
O.Reg 79/10 s. 72. (3)	CO #003	2014_306510_0019	146
O.Reg 79/10 s. 73. (1)	CO #001	2012_191107_0007	510a
O.Reg 79/10 s. 8. (1)	CO #001	2014_306510_0019	510a

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

The bed of an identified resident was observed to have two rails in the up position on specified dates. Personal support staff confirmed the resident used both side rails for bed mobility. As confirmed by registered staff, the only bed rail assessment, completed at admission, reported the resident did not use side rails and the care plan did not provide direction regarding the use of side rails. The plan of care did not set out clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The health record of an identified resident indicated that an RD assessment completed on a specified date, stated that the resident's wound was "healing as per documentation" of a specified date. However according to the nursing assessment completed on the specified date, the wound had actually increased in size and was painful to the resident. The next wound assessment completed at a later specified date indicated that the measurements of the wound had increased again. The nursing and the dietary assessments were not consistent with each other. This information was confirmed by the health record, the MDS coordinator and the ADRC. [s. 6. (4) (a)]

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 resident's written plan of care provides clear direction to staff and others who provide direct care to the resident and that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

On a specified date, an identified resident reported to the home that an identified staff person had been rough with the resident, leaving the resident feeling scared. The resident reported that the identified staff person, had violently pulled the sheet from under the resident. The resident was frightened of being tossed on the floor. The home's internal investigation deemed the incident abuse. When interviewed on a later specified date, the resident's recall matched the report given previously. The resident recalled being very scared of being injured. The resident was not protected from abuse by the identified staff member. This was confirmed by the resident, the administrator and the home's investigation notes. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an specified date an identified staff person transferred/turned an identified resident in a wheelchair, too quickly, resulting in the resident's knee hitting an assist rail. This resulted in a skin tear. This information was confirmed by the home's investigation notes, the health record and the Administrator. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

A summary document was provided by the home, of shifts during a specified time frame, when the RN scheduled to be on duty and present, became unavailable. On a specified number of occasions, there was no RN on site, in the home, to replace the scheduled staff member, for all or part of a shift. This was confirmed by the DRC. [s. 8. (3)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 home's policy "Abuse and Neglect - Zero Tolerance" was complied with.

Policy RR00-01 titled "Abuse and Neglect - Zero Tolerance" under procedure #14, directed that the Administrator or DRC would, in the event of alleged or witnessed abuse, notify the MOHLTC immediately. The home began an internal investigation of alleged staff to resident abuse on a specified date but did not notify the Director immediately. This was confirmed by the Administrator. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences. O. Reg. 79/10, s. 40.

It was reported that on an specified date, an identified resident was found in the dining room with a blanket over their knees. When the blanket was lifted, it was observed that the resident was not fully dressed. When interviewed, personal support staff were asked if a resident would be taken to the dining room dressed in this manner. Personal support staff stated no, it only happened once, for the identified resident. The resident was not dressed appropriately and in accordance with their preferences. [s. 40.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (iii) upon any return of the resident from an absence of greater than 24 hours;

An identified resident was in hospital during a specified time frame of more than 24 hours. Prior to the hospital transfer, a wound assessment completed on a specified date indicated that the resident had a wound, site and size specific. There was no re-assessment of the wound upon return from the hospital stay of over 24 hours. A wound assessment completed 2 days later indicated the measurement of the specified wound had increased. This was confirmed by the health record, the MDS coordinator and the ADRC. [s. 50. (2) (a) (iii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

A) On a specified date, an identified resident was observed to have the seat belt applied and hanging loosely at the thighs. Staff confirmed that the belt was not applied to manufacturers instructions, two finger breadths. The staff tightened the belt immediately.
B) On a specified date, an identified resident was observed to be wearing a lap belt while up in a wheelchair. The lap belt was hanging to the resident's thighs so an entire hand could fit between the belt and the resident. Staff confirmed that the belt was not applied according to manufacturer's instructions which stated that the belt should be secured across the hips so only two fingers could fit between the belt and the resident's body. Staff immediately tightened the belt. [s. 110. (1) 1.]

Issued on this 17th day of November, 2015

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

Original report signed by the inspector.