Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 6, 7, 2011.	2011_146_9610_06Jan102630	Complaint H-02542

Licensee/Titulaire
Regional Municipality of Niagara, 2201 St David's Rd., Thorold, ON., L2V 3Z3

Long-Term Care Home/Foyer de soins de longue durée
Northland Pointe, 2 Fielden Ave., Port Colborne, ON., L3K 6G4

Name of Inspector(s)/Nom de l'inspecteur(s)
Barb Naykalyk-Hunt, #146

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: the Director of Care (DOC), 2 registered staff, the RAI coordinator, 2 Personal Support Workers (PSW's), a Therapy Assistant and 2 residents.

During the course of the inspection, the inspector: reviewed the health file of an identified resident, interviewed the resident and observed his/her room, bed and chair.

The following Inspection Protocols were used during this inspection: Personal Support Services

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.6(1)

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,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The current care plan interventions, updated December, 2010, state to turn, reposition and toilet an identified resident according to the schedule posted in the resident's room. On both days of this inspection, there was no schedule posted in the resident's room, at the nurses' station nor in the PSW's flow binder. When 1 PSW was asked about the schedule and its contents, she was unsure if one existed, where it might be or what directions it contained.

WN #2: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.6(2)

6(2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Findings:

1. The current care plan of December 2010 states that an identified resident needs glasses for reading, however the resident states this information is incorrect. Resident was observed reading a book and a newspaper without glasses.
2. The current care plan of December 2010 states to apply TED stockings every morning and to remove at night. Resident states has not worn the stockings in several months because of complications. Doctor's note from June 2010 states to discontinue the vascular stockings.

WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.23

23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Findings:

1. On the date of inspection, the resident was sitting in a wheelchair on an inflatable pressure-relieving device. When asked by the inspector if it was comfortable, the resident replied that it was underinflated because the resident could feel the board under it. The inspector requested staff to check it. A therapy assistant took the resident off the unit to check it and later confirmed that the cushion had been flat. She re-inflated it. The therapy assistant, the resident nor the staff could say how long the cushion had been deflated.
2. 2 PSW's and a registered staff confirmed that they did not know how to check inflation status of the device and would not know if it was flat.
3. Manufacturer's instructions state to check inflation status of the device at least daily. There are no directions in the resident's plan of care or in health file or posted in room instructing staff to do so or how to do so.

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 related to staff using the ROHO cushions and mattresses following manufacturer's instructions , to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s.50(2)

50(2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Findings:

1. An identified resident's health file indicates that the resident has been assessed as high risk for skin breakdown due to the resident's skin being desensitized to pain and pressure and immobility.
2. On the first day of inspection, the identified resident was transferred from bed to wheelchair between 0600 and 0700 hours. At 1100 the resident stated he/she had not been repositioned since getting up (over 4 hours) and was uncomfortable.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Barbara Mayhugh Hall Feb 1 2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).