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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Sep 16, 2016	2016_341583_0016	024314-16	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

KELLY HAYES (583), ROSEANNE WESTERN (508)

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): August 22, 23, 24, 25, 26, 29, 30, 31 and September 1 and 2, 2016.

**The following inspections were conducted simultaneously with this Resident Quality
Inspection:
-Complaint Inspection log #021968-16 related to pain management
-Critical Incident Inspection log #005299-14 related to financial abuse; log #002280-15 related to financial abuse; log #007615-15 related to abuse; log #013968-15 related to falls management; log #023796-15 related to falls management; log #025781-15 related to falls management; log #028301-15 related to abuse; log #028510-15 related to abuse; log #029616-15 related to falls management; log #033030-15 related to abuse; log #035389-15 related to abuse; log #000340-16 related to abuse; log #001630-16 related to abuse; log 002499-16 related to abuse; log 009759-16 related to abuse; log #011588-16 related to falls management and log #018318-16 related to abuse.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Clinical Documentation and Informatics Lead (CDIL), Maintenance staff, Recreation Manager, Manager of Dietary/Housekeeping/Laundry, Registered Dietitian (RD), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care

Specifically failed to comply with the following:

s. 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. 2007, c. 8, s. 6 (2).

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. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

During an interview with resident #002 on an identified date in August 2016, the resident indicated that they did not like to have their dentures soaked at night and preferred to have their dentures cleaned and put back into their mouth at bedtime. The resident preferred to have their dentures in their mouth at all times.

The resident's plan of care under the care focus pertaining to the teeth or oral cavity directed staff to clean the resident's dentures twice a day, when necessary, and to remove and soak the resident's dentures at bedtime which was not the resident's preference.

It was confirmed during an interview with PSW's and the CDIL that the resident's plan of care was not based on an assessment of the resident's preferences. [s. 6. (2)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #204 was identified as having specified responsive behaviours. The resident's responsive behaviour plan of care indicated that the resident required one to one monitoring due to these behaviours.

On an identified date in 2015, staff #117 directed staff #030 who was assigned to provide the one to one monitoring of resident #204, to assist on the floor with other residents instead of providing the care to resident #204 due to a staffing shortage.

The resident's plan of care also directed staff to apply an intervention at snack and meal times only. Staff #117 also directed staff #030 to apply this intervention to the resident's chair before and after breakfast on an identified date in 2015.

It was confirmed during an interview with staff #030 and through investigative notes and the Critical Incident report submitted by the home, that the care set out in the plan of care was not provided to the resident as specified in the plan.

PLEASE NOTE: This area of non compliance was identified during a CI report inspection, log #033030-15, conducted concurrently during this RQI. [s. 6. (7)]

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 care set out in the plan of care is provided to resident's as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) On an identified date in 2015, a letter was found in resident #108's drawer that asked for money from registered staff #147.

In an interview conducted by the home on an identified date in 2015, registered staff #147 shared they had not approached residents or families for money, they did not provide letters to any residents other than resident #108 and that they did not take money directly from residents.

Through interviews and signed statements completed during the homes investigation it was confirmed resident #108 was approached by registered staff #147 for money and gave a specified amount on two occasions. It was also confirmed family members were approached and gave money to registered staff #147.

This area of non-compliance was identified during an inspection of a Critical Incident (CI) report, log #002280-15, conducted concurrently during this Resident Quality Inspection (RQI). (583)

B) On an identified date in 2016, resident #209 reported to staff #121 that on an identified date in 2016, staff #117 threw a towel towards them and made specified comments when the resident required treatment. The resident also told staff #121 that on several occasions staff #117 complained to them about the length of time their care need required.

Resident #209 reported that the comments made by staff #117 intimidated them and made them feel like their care needs were their fault. Staff #121 verified that the resident was upset by staff #117's actions towards them during their conversation on an identified date 2016.

It was confirmed during an interview staff #121 and during an interview with the Director of Care that resident #209 was not protected from emotional abuse by staff #117.

PLEASE NOTE: This area of non-compliance was identified during an inspection of a Critical Incident (CI) report, log #001630-16, conducted concurrently during this Resident Quality Inspection (RQI). (508)

C) On an identified date in 2016, resident #208 reported to staff that a PSW who had provided care to them that morning had been rough with them and shared it caused pain. The resident pointed to the area of their body where they felt pain and it was observed by staff #072 and staff #033 that the resident had red marks located in this area.

The PSW's reported the incident to the Registered Nurse (RN) who confirmed through an assessment of the resident that the resident had injuries including a red mark.

Clinical records and internal investigative documentation confirmed that resident #208 was not protected from abuse by staff in the home. This was also confirmed during an interview with the DOC.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) report inspection, log #009759-16, conducted concurrently with this Resident Quality Inspection (RQI). (508)

D) It was witnessed by staff on an identified date in 2015, in the common area of an identified unit, that staff #117 yelled at resident #203 who was cognitively impaired. Staff #117 then made specified comments which caused the resident to cry. More specified comments were again directed towards resident #203 by staff #117.

Staff and investigative notes confirmed that the resident had been yelled at by staff #117 which caused the resident to become upset and cry.

It was confirmed by the DOC that residents were not protected from abuse by staff in the home.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) report inspection, log #033030-15, conducted concurrently during this Resident Quality Inspection (RQI). (508) [s. 19.]

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 all residents are protected from financial, physical and emotional abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The license failed to ensure that no resident of the home was restrained for the convenience of the licensee or staff.

Resident #204 required a specified intervention be applied to their chair during meal and snack times due to cognitive impairment and identified responsive behaviours. The resident also required increased monitoring and was assigned one to one staff to resident care.

On an identified date in 2015, the unit where the resident resided was short staffed by one PSW from 0700 - 0800 hours. Shortly after 0700 hours, the PSW assigned to resident #204 offered to assist staff with other residents. The RPN on the unit told the PSW to restrain resident #204 in their chair before assisting the other residents.

Approximately 30 minutes later, the PSW went to release the resident from their restraint and was instructed by the RPN to leave the resident restrained and shower another resident. The PSW complied and left the resident restrained to assist another resident.

The resident remained in the restraint for breakfast and at 0900 hours, the PSW was instructed by the RPN to keep the resident restrained to complete documentation which took approximately 25 minutes.

It was confirmed during an interview with staff #030 and through documentation that resident #204 was restrained for the convenience of staff.

PLEASE NOTE: This area of non compliance was identified during a CI report inspection, log #033030-15, conducted concurrently with this RQI. [s. 30. (1) 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 no residents are restrained for the convenience of staff, to be implemented voluntarily.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Resident #203 had an unwitnessed fall on the evening of an identified date in 2016. The resident was found on the floor of their room by a PSW staff and the RPN was notified to conduct a post-fall assessment on the resident.

The home's Post Fall Assessment policy, #PCS04-011, directed staff to assess residents and to complete the Risk Management Report and the Post Fall Assessment in Point Click Care (PCC).

A review of the Post Fall Assessment completed on an identified date in 2016, at a specified time, under pain assessment and vitals, revealed that a pain assessment at the time of the incident had not been conducted. The information documented in this section was information from a previous assessment conducted two days earlier, which indicated that the resident did not have any pain.

It was confirmed by the CDIL during an interview that the Post Fall Assessment policy had not been complied with.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #021968-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 8. (1) (a),s. 8. (1) (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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed.

On an identified date in 2015, resident #103 and #104 demonstrated responsive behaviours towards each other during the dinner service. Resident #103 sustained two minor injuries from the altercation.

On an identified date in 2015, approximately two weeks later resident #103 and #104 responsive behaviours towards each other and both residents fell to the floor before staff could intervene. Resident #104 sustained two minor injuries and resident #103 sustained one minor injury.

A review of the plan of care identified after the two incidents occured that resident #103 and #104 did not have responsive behaviour care plans that identified their specified responsive behaviours. In an interview with the CDIL it was confirmed that strategies, including techniques and interventions, to prevent, minimize or respond to resident #103 and #104's responsive behaviours had not been written in their care plans.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) report inspection, log #028301-15, conducted concurrently during this Resident Quality Inspection (RQI). [s. 53. (1) 2.]

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 written strategies, including techniques and interventions, to prevent, minimize or respond to responsive behaviours are developed, to be implemented voluntarily.

WN #6: 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 failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

On an identified date in 2015, on a specified unit of the home, staff witnessed staff #117 yelling at resident #203 making specified comments which caused the resident to cry.

The home's Abuse and Neglect - Zero Tolerance policy, # RR00-001, 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 was made by anyone other than a resident.

The policy also stated that a report of an alleged or witnessed incident of abuse or neglect must be reported to the Director of Resident Care, Administrator, or designate immediately. The Administrator or DRC will notify the Ministry of Health and Long Term Care (MOHLTC) immediately and will complete the Critical Incident (CI) report on the Ministry web-site.

Staff #030 did not report this incident immediately as directed in the home's policy. The Associate Director of Resident Care did not become aware of the incident until four days after the incident occurred and therefore, the office of the MOHLTC did not receive the CI report until five days after the incident.

It was confirmed by the Director of Resident Care (DRC) during an interview that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) report inspection, log #033030-15, conducted concurrently during this Resident Quality Inspection (RQI). [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to a resident under a program including interventions were documented.

A review of resident #101’s plan of care identified they had a fall on a specified date in September 2015, at a specified time which resulted in an injury and the resident shared they had pain. In the post fall progress note it was documented that a note was put in the communication book to phone the resident 101’s substitute decision maker (SDM) in the morning.

The following day, resident #101 had a second fall which resulted in a transfer to hospital and where it was confirmed the resident sustained a injury. In the post fall progress note it was documented that the SDM was notified of the fall.

In an interview with the DRC, it was confirmed that there was no documentation in resident #101’s plan of care that identified if the SMD was notified of the first fall with injuries.

PLEASE NOTE: This area of non-compliance was identified during a CI report inspection, log #025781-15, conducted concurrently during this RQI. [s. 30. (2)]

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 failed to ensure that the resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident was required.

A review of the Minimum Data Set (MDS) coding for resident #002, continence in last 14 days, indicated that resident #002 was incontinent of bladder and usually continent of her bowels in January, 2016. In April, 2016, the resident's bladder incontinence improved to where the resident had some control present.

In July, 2016, the resident's bladder incontinence remained the same; however, resident #002 declined and became occasionally incontinent of their bowels.

A review of the resident's clinical records indicated that the resident had not been reassessed when the resident's incontinence changed.

It was confirmed during an interview with the CDIL, that the resident who was incontinent did not receive an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident was required. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken in response to an incident, including, the outcome or the current status of the individual who were involved in the incident made a report in writing to the Director.

A) Resident #202 had a fall which resulted in a transfer to hospital on an identified date in August 2015. It was confirmed in the hospital that the resident sustained an injury and the resident was hospitalized for a specified number of days.

The home submitted a Critical Incident (CI) report on a specified date in 2015, notifying the Director of the incident. On a specified date in 2015, a request was sent to the home from the Director to update the CI to provide information on the status of the resident and the resident's date of re-admission to the home.

The CI was not amended to provide this information to the Director. This was confirmed by the Director of Resident Care.

PLEASE NOTE: This area of non compliance was identified during a CI report inspection, log #023796-15, conducted concurrently during this RQI. (508)

B) Resident #102 had a fall which resulted in a transfer to hospital on a specified date in October 2015. It was confirmed that the resident sustained an injury. The home submitted a Critical Incident (CI) report on a specified date in October 2015, notifying the Director of the incident. On a specified date in October 2015, a request was sent to the home from the Director to update the CI to provide the date of the resident’s return, status upon return and any additional falls prevention and management strategies implemented. The CI was not amended to provide this information to the Director. This was confirmed by the DRC.

PLEASE NOTE: This area of non-compliance was identified during a CI report inspection, log #028510-15, conducted concurrently during this RQI. (583) [s. 107. (4) 4.]

Issued on this 19th day of September, 2016

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

Original report signed by the inspector.