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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
September 7, 8, 9, 10, 2010	2010_107_9610_07Sep111641	Dietary Follow Up H-00943

Licensee/Titulaire
The Regional Municipality of Niagara
2201 St. David's Road
Thorold ON
L2V 4T7
905-685-1571 phone
905-685-6243 fax

Long-Term Care Home/Foyer de soins de longue durée
Northland Pointe
2 Fielden Avenue
Port Colbourne ON
L3K 6G4

Name of Inspector(s)/Nom de l'inspecteur(s)
Michelle Warrener - #107

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection in respect of the following previously identified non-compliance:
A1.11 (2) – Nutritional complaint June 16/09
B3.23 – Nutritional – Jan 30/08
B3.24 – Nutritional – Jan 30/08
B3.25 – Nursing - June 12/07
M1.18 – Nutritional Jan 30/08
P1.14 – Nutritional Oct 28/08
P1.15 – Nutritional June 16/09
P1.18 – Nutritional June 16/09
P1.22 – Nutritional Jan 30/08
P1.27 – Nutritional June 16/09
P1.29 – Nutritional Jan 30/08
P1.4 – Nutritional June 16/09

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Food Service Manager, Food Service Supervisor, Registered Dietitian, Dietary Aides, Cook, Residents, nursing staff (RN, RPN, PSW, HCA)

During the course of the inspection, the inspector:
Reviewed health care records, reviewed policy and procedures, observed meal service, observed care, toured the home, observed staff in routine duties.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Dining Observation
Food Quality

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

[10] WN
[6] VPC
[2] CO: CO # 1, 2

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

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 LTCHA, 2007, S.O 2007, c.8, s. 6 (10) (b), (c)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective.

Findings:

1. A resident was not re-assessed when the resident's status changed (no longer wanders), however, the September 8, 2010 nutritional assessment does not include an evaluation of the effectiveness and need for the current interventions. The current interventions restrict the resident's movement and do not allow the resident to be seated at a table with other residents.
2. The nutritional plan of care for a resident was not reviewed and revised when the care set out in the plan was not effective. Nutrition interventions for the treatment of constipation were not evaluated for effectiveness at the August, 2010 nutrition quarterly and were not revised when ineffective. The resident has experienced ongoing constipation without revision to or an evaluation of the dietary interventions.

Inspector ID #:	107

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 with ensuring that residents are reassessed and the plan of care reviewed and revised when the care needs change or care set out in the plan is no longer necessary and when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, 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.

Findings:

The care set out in the plan of care was not provided to the following residents:

1. A resident did not receive the correct consistency of thickened fluids (received thin fluids) at the afternoon snack pass September 8, 2010, creating a risk for choking/aspiration.
2. A resident did not receive interventions according to their written plan of care. The plan of care states the resident is not to receive certain foods due to a nutritional restriction ordered by the physician, however, the resident received the restricted food at the lunch meal September 8, 2010. Documentation on the resident's food and fluid intake records also identifies restricted foods were given at snack time.
3. A resident is to receive a nutritional supplement at the lunch meal, however, the resident did not receive it at the lunch meal September 8, 2010. The resident is underweight and eats poorly. The

resident confirmed they did not receive the supplement at the lunch meal.

4. A resident's plan of care states they are to receive a nutritional supplement with meals, however, they did not receive it at the lunch meal September 8, 2010. The resident's plan of care also states they are to receive special nutrition interventions with every meal, however, they did not receive the special intervention, resulting in reduced nutritive value of the meal.
5. A resident's plan of care states they are to receive a special nutrition intervention at the supper meal. They did not receive this at the supper meal September 8, 2010.
6. A resident has a plan of care that requires a special beverage at lunch, however, the resident did not receive it at the lunch meal September 8, 2010.

Inspector ID #:	107

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 with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, s. 6 (9) 1
The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

Findings:

The provision of the care set out in the plan of care is not documented for the following residents:

1. A resident has a plan of care to provide a nutritional supplement at all meals. For the month of August, the supplement is documented at 41/93 meals.
2. A resident has a plan of care to provide a nutritional supplement at the supper meal. The supplement is documented 12/31 days for the month of August 2010. The resident has a plan of care to provide a different nutritional supplement at the lunch meal. The supplement is documented 13/31 days for the month of August 2010.
3. A resident has a plan of care to provide a nutritional supplement at all meals, a different nutritional supplement at the morning and afternoon snack pass, and special food with every meal. The supplements and special food are not consistently documented for the month of August 2010. It is unclear from the documentation if the items were provided and not documented, refused or not offered.

Inspector ID #:	107

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 with ensuring that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s. 129(1)(a)(ii)
Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked

Findings:

1. At 16:05 September 8, 2010, the medication cart on the secured unit was left unlocked and unattended with poured crushed medications sitting on top of the cart. The Inspector was able to open the cart and access medications without staff members present.

Inspector ID #:	107

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 with ensuring that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg. 79/10, s. 26(4)(b)

(4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,

(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).

Findings:

1. The Registered Dietitian did not complete a nutritional assessment for a resident in relation to the resident's uncontrolled diabetes. The resident had 20 episodes of hypoglycemia from July 1 - September 10, 2010, without assessment by the Registered Dietitian.
2. The Registered Dietitian did not complete a nutritional assessment for a resident in relation to the resident's uncontrolled diabetes. The resident had 23 episodes of hypoglycemia from July 1 - September 10, 2010, without assessment by the Registered Dietitian. The resident does not consume snacks in the evening, and all but two of the low blood sugars happened in the morning. This has not been assessed by the Registered Dietitian.
3. A resident is documented as having significant open areas in July, 2010, however, has not been assessed by the Registered Dietitian in relation to skin integrity. In August, 2010, documentation indicates the resident has received numerous laxatives and suppositories in the past month for constipation and a referral has been made to dietary to assess the need for increase in fiber to help decrease constipation. This has not been assessed by the Registered Dietitian. The resident is documented as having poor fluid intake in August, 2010, and in September, 2010 discussion was held with the Power of Attorney related to the need for an alternative treatment, however, the Registered Dietitian has not completed an assessment of the resident's hydration status.
4. A resident did not have their swallowing problem professionally assessed by the Registered Dietitian. The Feeding/Swallowing screening tool is completed by non-Registered staff who observe the resident during meals. This tool is used to determine the need for diet texture changes, changes to fluid consistency, and difficulties with chewing and swallowing. The resident did not receive a complete nutrition assessment by the Registered Dietitian in relation to chewing and swallowing ability. A nutritional supplement was implemented for this resident, however, the Registered Dietitian did not complete an assessment of the supplement quantity and timing in relation to the resident's assessed nutritional requirements and current dietary intake.

Inspector ID #:	107

Additional Required Actions:

CO # 001 - will be served on the licensee. Refer to the "Orders of the Inspector" form.

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s. 69.1 and 2

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.

Findings:

1. A resident has not been assessed by the Registered Dietitian after a 10% weight loss in July, 2010 and care planning interventions have not been revised or implemented to address the weight loss. The resident is underweight. Progress notes indicate a referral to the Registered Dietitian was initiated in July, 2010, however, it has not been completed to date (September 8, 2010). The resident is documented as having significant skin integrity concerns in July, 2010.
2. A resident had a documented weight loss of 13.6% over three months triggered in August, 2010, without an assessment by the Registered Dietitian. Nutrition interventions were not revised or implemented to address the weight loss. The resident is underweight.

Inspector ID #:	107

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 with ensuring that residents with a change of 5 per cent of body weight, or more, over one month and a change of 7.5 per cent of body weight, or more, over three months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg. 79/10, s. 72(2)(f)

(2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions

Findings:

1. Pureed potato salad was not prepared and available at the lunch meal service September 7, 2010 in the Lakeside dining room. Pureed macaroni salad was served instead. Residents and staff were not informed of the menu substitution.

Inspector ID #:	107

WN #8: The Licensee has failed to comply with O.Reg. 79/10, s. 72(3)(a)

The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality.

Findings:

Not all foods were prepared using methods which preserve taste, nutritive value, appearance and food quality:

1. The recipe was not followed for the tuna melt served September 7, 2010 lunch meal service, resulting in reduced protein and reduced nutritional value of the meal.
2. The recipe was not followed for the deli meat plate served at the lunch meal September 7, 2010, resulting in reduced nutritive value, appearance and taste.
3. The pureed sauteed peppers served to residents at the lunch meal September 7, 2010 were too runny

resulting in reduced appearance, reduced nutritive value (too much fluid resulting in a less nutrient dense product), and created a choking risk for residents requiring thickened fluids.

Not all foods were served to residents using methods which preserve taste, nutritive value, appearance and food quality:

1. The planned portion size of menu items was not followed at the lunch meal September 7, the lunch meal September 8, and the supper meal September 8, 2010, resulting in reduced or varied nutritive value. Portions served to residents were often less than the planned menu. Some examples: ½ versus a whole tuna melt; #10 versus #8 scoop for pureed pizza (smaller portion); #8 versus #10 (larger portion) for minced brussel sprouts; #10 versus #8 for sweet and sour pork (smaller portion); #12 versus #10 for minced sweet and sour pork (smaller portion); #10 versus #6 for pureed sweet and sour pork (smaller portion); #12 versus #8 for rice (smaller portion); #6 versus #8 for oriental vegetables (larger portion); #12 versus #10 for pureed zucchini (smaller portion).
2. Two staff were observed stirring together pureed tuna melt with pureed sauteed peppers while feeding two residents , resulting in reduced appearance and taste.
3. Staff were adding almost a whole glass (250ml) of milk to pureed soup served to a resident at the lunch meal September 7, 2010, resulting in reduced taste and food quality.

Inspector ID #:	107

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 with ensuring that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg. 79/10, s. 73(1)6, 8, 9

Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

6. Food and fluids being served at a temperature that is both safe and palatable to the residents.

8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Findings:

1. Minced potato salad for the cold deli plate was served to residents at the lunch meal September 7, 2010 at 20 degrees Celsius which is not palatable.
2. At the supper meal September 8, 2010 in the Port Place dining room, meals were not served course by course. Meal service began at 5:00pm, however, desserts were placed on tables 2 while residents were still consuming the entrée (5:11pm desserts were on tables), creating a rushed dining experience for residents.
3. A resident was not provided with the required level of assistance with eating and drinking at the observed lunch meal September 10, 2010. The resident was left with fluids (nutritional supplement and apple juice) in-front of them, however, staff were not available to provide assistance. The resident's plan of care states total feeding assistance is required.

Inspector ID #:	107

WN #10: The Licensee has failed to comply with O.Reg. 79/10, s. 8(1)(b)

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,

(b) is complied with.

Findings:

The Licensee's policy Number C030526 Hypoglycemic Treatment is not followed by staff providing care to residents.

The Licensee's policy was not followed for three of three residents reviewed experiencing hypoglycemia:

From July 1 - September 10, 2010, a resident had nine episodes of low bloods sugar (< 4mmol/L) or severely low (< 2.8mmol/L) without evidence of treatment for the hypoglycemia.
Treatment provided did not follow the protocol on five occasions. Follow up was not completed to ensure blood sugars had returned to normal prior to discontinuation of treatment and/or the treatment provided was not consistent with types of items or quantities of items required as per the protocol.

From July 1 - September 10, 2010, a resident had eight episodes of low bloods sugar (< 4mmol/L) or severely low (< 2.8mmol/L) without evidence of treatment for the hypoglycemia.
Treatment provided did not follow the protocol on 10 occasions. Follow up was not completed to ensure blood sugars had returned to normal prior to discontinuation of treatment and/or the treatment provided was not consistent with types of items or quantities of items required as per the protocol.

In July, 2010 a resident had a low blood sugar recorded, however, the treatment provided did not follow the protocol.

Inspector ID #: 107

Additional Required Actions:

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

CORRECTED NON-COMPLIANCE Non-respects à Corrigé				
REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
LTCHA, 2007, S.O. 2007, c.8, s. 3 (1) 4 (previously issued as A1.11)			06/16/2009 Nutritional	
O.Reg. 79/10, LTCHA, 2007, s. 68 (2) (d) (previously issued as B3.25)			06/12/2007 Nursing	
O.Reg. 79/10, LTCHA, 2007, s. 71 (2) (b) (previously issued as P1.4)			06/16/2009 Nutritional	

O.Reg. 79/10, LTCHA, 2007, s. 71 (6) (previously issued as P1.15)			06/16/2009 Nutritional	
O.Reg. 79/10, LTCHA, 2007, s. 71 (3) (previously issued as P1.18)			06/16/2009 Nutritional	
LTCHA, 2007, S.O. 2007, c.8, s. 11 (1) (a) (previously issued as P1.27)			06/16/2009 Nutritional	

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.** [signature]
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). October 15, 2010

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
Direction de l'amélioration de la performance et de la conformité

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

Name of Inspector:	Michelle Warrener	**Inspector ID #**	107
Inspection Report #:	2010_107_9610_07Sep111641		
Type of Inspection:	Dietary Follow Up H-00943		
Licensee:	The Regional Municipality of Niagara 2201 St. David's Road Thorold ON L2V 4T7 905-685-1571 phone 905-685-6243 fax		
LTC Home:	Northland Pointe 2 Fielden Avenue Port Colbourne ON L3K 6G4		
Name of Administrator:	Joy Misztal		

To the Regional Municipality of Niagara, you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O.Reg. 79/10, s. 26(4)(b)
(4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).

Order:
The Licensee shall review all residents, including the identified residents, and shall ensure that the Registered Dietitian assesses residents' nutritional status, including and any risks related to nutrition such as diabetes management, skin integrity, constipation, swallowing problems, nutritional supplement quantity and timing in relation to the residents' assessed needs, with actions taken and outcomes evaluated as appropriate.

Grounds:

1. The Registered Dietitian did not complete a nutritional assessment for two residents in relation to the residents' persistent hypoglycaemia.
2. The Registered Dietitian did not assess an identified resident in relation to poor skin integrity, ongoing constipation and poor hydration, despite a referral initiated in August.
3. An identified resident did not have their swallowing problem professionally assessed by the Registered Dietitian. A nutritional supplement was implemented for this resident, however, the Registered Dietitian did not complete an assessment of the supplement quantity and timing in relation to the resident's nutritional requirements and current dietary intake.

This order must be complied with by:	December 31, 2010

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O.Reg. 79/10, s. 8(1)(b)

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,

(b) is complied with.

Order:

The Licensee shall review all residents experiencing hypoglycaemia, including the identified residents, and develop and submit a written plan that outlines how the Licensee will ensure the policy and procedure related to hypoglycaemia management is followed.

Grounds:

The Licensee's policy Number C030526 Hypoglycemic Treatment is not followed by staff providing care to three identified residents.

This order must be complied with by:	October 29, 2010

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board **and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 15th day of October, 2010.	
Signature of Inspector:	M Warrener
Name of Inspector:	Michelle Warrener
Service Area Office:	Hamilton Service Area Office