Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A3)

Amended Report Issue Date: March 21, 2024	
Original Report Issue Date: November 7, 2023	
Inspection Number: 2023-1605-0004 (A3)	
Inspection Type: Complaint	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: Northland Pointe, Port Colborne	
Amended By Nishy Francis (740873)	**Inspector who Amended Digital Signature** Nishy Francis (740873)

AMENDED INSPECTION SUMMARY

This report has been amended to reflect a Director's determination.

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Lead Inspector Nishy Francis (740873)	**Additional Inspector(s)**
Amended By Nishy Francis (740873)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to reflect a Director's determination.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27 - 29 and October 3 - 5, 10, 13, 2023.
The inspection occurred offsite on the following date(s): October 12, 16 - 20, 2023.

The following intake(s) were inspected:

- Intake: #00095982 related to admissions and discharges, resident care and support services, and resident choices,

- Intake: #00096464 related to continence care, food, nutrition and hydration, and medication management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Residents' Rights and Choices
Admission, Absences and Discharge

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
The physician ordered a medication for a resident and directed staff to inform the Substitute Decision Maker (SDM) prior to each administration.

On an identified date, the resident was provided medication without informing the SDM prior to administration.

When the home did not inform the SDM and administered the medication, the home failed to provide care to the resident as specified in the plan of care.

Sources: Interview with staff; review of resident's clinical record, home's investigative notes. [740873]

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