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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2012	2012_191107_0007	H-001698-12	Complaint

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): December 13, 14, 2012

Complaint inspection H-001698-12

During the course of the inspection, the inspector(s) spoke with multiple residents, the Administrator, Nutrition Manager, Registered Nursing staff, and front line nursing and dietary staff.

During the course of the inspection, the inspector(s) observed the evening and lunch meals, and reviewed the plan of care for all residents in one home area.

The following Inspection Protocols were used during this inspection:
Dining Observation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) 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:
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

s. 73. (1) 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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) 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:
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. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)3]
Meal service was not consistently provided in a congregate dining setting unless a resident's assessed needs indicated otherwise.
a) At least eight residents were noted to consistently receive tray service at breakfast, supper or both meals. Interview with one resident identified that they were offered tray service at all meals throughout the day, however, the resident stated they did not think it was healthy to stay in bed all day and chose to have meals in bed at one meal only.
b) Another resident interviewed identified that they were provided tray service as it took too long to get them up in the morning due to requiring the use of a lift.
c) Staff interviewed identified concerns with residents who required assistance with eating or transferring with a lift being left in bed for meals and often consuming two of three meals in bed.
d) Resident #01 was noted to be in bed for both the supper and breakfast meal, however, their plan of care did not identify an assessed need for eating their meals in bed. Staff interviewed stated that the resident was not to be in bed over the supper meal and should have been brought to the dining room. [s. 73. (1) 3.]

2. [O.Reg. 79/10, s. 73(1)4]
Not all residents were monitored during the breakfast meal in an identified home area December 14, 2012. Prior to 9:03 a.m, three residents (Residents #02,03,04) were noted to have food and fluids in-front of them in the dining room, however, nursing and dietary staff were not present within eye sight or in the dining/nursing station areas. Staff did not return to the dining area until 9:08 a.m and residents were again left unattended in the dining area (food and fluids still on the tables) from before 9:19 a.m until 9:25 a.m. Staff interview confirmed that residents were not to be left unsupervised in the dining rooms when there was food and fluids on the tables. [s. 73. (1) 4.]

3. [O.Reg. 79/10, s. 73(1)9]
Not all residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during the supper meal December 13 and the lunch meal December 14, 2012. Some examples:
a) At the lunch meal resident #08 had their meal placed on the table and then removed (untouched) half an hour later without staff providing any type of prompting or assistance. The resident's beverages were also removed without being touched by the resident. The resident's plan of care stated they required extensive assistance by

staff for eating. Staff assisted the resident sitting beside this resident, however, did not provide assistance to this resident.
b) Resident #02 had a plan of care requiring extensive staff assistance with eating, however, the resident sat at the table without assistance for 15 minutes at the supper meal and at the lunch meal the entree was placed on the table and the resident did not eat independently. The resident's meal was removed, virtually untouched. At the supper meal the day prior, the staff sat with the resident and assisted with eating and the resident was much less disruptive in the dining area. Staff stated the resident's behaviour and eating was much better when staff sat with them, however, they stated they often do not have the staff available to do so.
c) Resident #03 sat for 15 minutes without assistance at the supper meal and their meal was removed without eating. The resident's plan of care identified supervision with minimal assistance required, however, staff interview identified an increased need for assistance with staff often having to feed the resident their meal. At the lunch meal they were not assisted with eating and ate poorly. The resident's meal was removed and dessert placed, however, the resident had 1 spoon of dessert and stopped eating without encouragement or assistance for 10 minutes. The verbal prompting was ineffective and the resident was noted to be sleeping at the table without eating their dessert for the rest of the meal.
d) Resident #05 required limited assistance by 1 staff at meals, however, they were not assisted with their beverages at the supper meal. The resident required assistance to identify the location of items on the table. The resident did not consume their beverages during the meal and staff did not assist the resident with their beverages until the Inspector identified they did not consume anything to drink 1 hour later. When the beverages were placed in the resident's hand, they consumed the beverages. The resident was offered their tea at the end of the meal, however, they stated it was now cold and they did not want to drink it. Assistance with beverages was not provided throughout the meal. At the lunch meal, the resident was assisted with the positioning of their entree, however, the resident was not assisted with their beverages. The resident was removed from the dining room without consuming their fluids.
e) Resident #06 required limited assistance by 1 staff at meals. Assistance was not provided for 10 minutes and the resident did not eat until staff were available to sit with the resident and assist at the supper meal. At the lunch meal, the resident had their meal placed on the table without assistance being provided. Verbal cueing was provided half an hour later, however, the verbal prompting was unsuccessful and the resident did not eat and had minimal fluid intake (approx 75ml). The resident picked

at their meal and did not appear to know what to do with it. The resident was removed from the dining room without consuming their meal.
f) Resident #07 left the dining area prior to finishing their entree and prior to dessert, without encouragement to stay in the dining room at the supper meal. The resident consumed minimal fluids and less than 50% of their meal. At the lunch meal the resident took beverages and soup only and then left the dining room. Staff stated they can't get the resident to stay in the dining room for meals, however, their plan of care did not identify this need and did not identify strategies to ensure the resident was offered a full meal. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 home has a dining and snack service that includes, meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise and monitoring of all residents during meals, to be implemented voluntarily.

WN #2: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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1. [O.Reg. 79/10, s. 51(2)(c)]
The licensee did not ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.
At 6:10 p.m on the evening of December 13, 2012, resident #09 rang the call bell and requested assistance with toileting. While the inspector was present, staff answered the call bell and told the resident that they would have to wait as the staff member was going on break. The staff member stated that since there were only two staff on in the evening (one PSW was feeding a resident in their room) and this PSW was leaving on break that the resident would have to wait until the other staff was available. The bell was answered 12 minutes later by the RPN who assisted the resident with toileting. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #3: 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. [O.Reg. 79/10, s. 40]
The licensee did not ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences. During the supper meal December 13, 2012, three residents (#10,11,12) were dressed in their bed clothes. Staff interview identified the residents had had a bath prior to the supper meal and were then placed in their night clothes. Interview with one of the identified residents confirmed that the resident was not asked their preference of dress and they were placed into their bed clothes without asking the resident. Staff interview also identified that this was a common practice. Interview with the Registered staff confirmed that the home's policy was to place residents in their day clothes if they received a bath prior to the evening meal. None of the identified residents had an identified preference for being in their bed clothes prior to the dinner meal. [s. 40.]

Issued on this 21st day of December, 2012

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2012_191107_0007
Log No. / Registre no:	H-001698-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 18, 2012
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	NORTHLAND POINTE 2 Fielden Avenue, PORT COLBORNE, ON, L3K-6G4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JOY MISZTAL~~ Leslie Hancock

To THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The Licensee must prepare, submit, and implement a plan that outlines how the home will ensure that:
a) the identified residents receive the required level of assistance and encouragement at meals
b) residents requiring assistance with eating are identified by staff in the dining areas and that the residents' plans of care reflect the current level of assistance required for eating
c) staffing patterns and seating plans are reviewed to ensure sufficient staff are available to provide the required level of assistance with eating at all meals
d) education related to assistance with eating is provided to all Registered and front line staff
The plan shall include a system to monitor, analyze, and evaluate the effectiveness of strategies identified in the plan.
The plan is to be submitted electronically to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca. The plan is to be submitted by January 11, 2012 and compliance is required by March 31, 2012.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)9]
Not all residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during the supper meal December 13 and the lunch meal December 14, 2012.
Some examples:
a) At the lunch meal resident #08 had their meal placed on the table and then removed (untouched) half an hour later without staff providing any type of prompting or assistance. The resident's beverages were also removed without being touched by the resident. The resident's plan of care stated they required extensive assistance by staff for eating. Staff assisted the resident sitting beside this resident, however, did not provide assistance to this resident.
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Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2013

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of December, 2012

Signature of Inspector / Signature de l'inspecteur : M Warrener, RD

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

Service Area Office / Bureau régional de services : Hamilton Service Area Office