Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 8, 2013	2013_105130_0029	H-000560-13	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

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 16,17, and 19, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Resident Care (DRC), Assistant Director of Care (ADOC), Registered Staff, personal support workers and residents related to H-002249-12, H-000560-13 and H-000240-13.

During the course of the inspection, the inspector(s) Interviewed staff and residents, reviewed clinical records, reviewed relevant policies and procedures, reviewed incident reports and critical incident reports and observed care.

The following Inspection Protocols were used during this inspection:
Medication

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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. 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 did not ensure that any plan, policy, protocol, procedure, strategy or system was complied with. The home's Medication Reconciliation Policy 7-2, Section 7, Admission/Discharge/Transfer of Residents, indicated that reconciliation was to be completed: At the time of admission or readmission to the long term care facility and following a consultation with a specialist resulting in medication changes. The medication reconciliation is a multidisciplinary process lead by the nurse. The nurse creates the Best Possible Medication History (BPMH) with information obtained from the resident, resident's family or responsible party, transferring home or hospital, Community Care Access Centre (CCAC) and previous pharmacy. Whenever possible at least two sources of information are to be used to complete the BPMH. The physician will use the information gathered in determining the admission orders. Procedure #3. Record a complete and accurate list of resident's current and preadmission medications including name, dosage,frequency and route. Include any vitamins, herbal or alternative medications, over the counter medication and supplements the resident may have been taking. Procedure #7. Contact the physician and review the list of medications in detail, obtaining an order for each one to "continue" or "discontinue". Procedure #19. Second nurse reviews all processing steps, checks that the medications and labels received from pharmacy match written order in chart, signs and adds, date and time. Procedure #24. Procedures following specialist consultation or after dialysis: Document new orders on Medication Administration Record, note any changes to previous medication regime in progress notes in resident's chart, clarify any discrepancies with attending physician.

a) In 2013, resident #002, returned to the home from a specialist appointment with new physician's orders, which required clarification. Registered staff did not clarify the order with the specialist until a later date. As a result, the resident did not receive the medication ordered by the specialist for a period of five days. The home confirmed that registered staff should have clarified the order with the attending physician as per their policy and not waited to clarify with the specialist.

b) Resident #003 was admitted for a short stay in 2012. During their temporary stay, the resident received the incorrect dosage of medication. The home confirmed that the staff did not reconcile the new medication list as per their policy and had they done so, the error would not have occurred. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 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. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

a) The plan of care for resident #001, indicated the resident was dependent on staff for repositioning. In 2013, the resident was observed in their wheelchair from approximately 1030 hours until 1500 hours. The resident was not repositioned during the observed hours. The resident stated feeling uncomfortable in the chair and verified that they had not been repositioned during the observed time frame. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

a) The plan of care for resident #002, specifically the narrative care plan, indicated the resident had difficulty breathing related to a specific diagnosis and therefore required oxygen (O2) at a specific flow rate via nasal canula, as per the physician's order. However, the progress notes, medication administration record and physician's order indicated a different flow rate. Staff verified the plan did not provide clear directions regarding the oxygen flow rate.

b) The Minimum Data Set (MDS) Assessment completed on 2013, for resident #006, indicated the resident had some or all of own teeth, required daily cleaning of teeth or dentures or daily mouth care by resident or staff. The narrative care plan indicated, has dentures: partial uppers which resident refuses to wear and usually takes out; has own teeth. The plan did not provide clear direction regarding oral hygiene requirements, specifically the frequency and level of assistance required. This information was verified by staff. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident and preferences of that resident.

a) The MDS assessment completed in 2013, for resident #001, indicated the resident had own teeth, had an electric toothbrush and was able to brush own teeth with set up help from staff. The care plan and kardex indicated the resident had an electric toothbrush and required total assistance with all aspects of oral hygiene. The resident was interviewed and indicated set up help was required, but they were able to perform the remainder of the task independently. Staff interviewed confirmed the resident required set up help only. [s. 6. (2)]

3. The licensee did not ensure that the care set out in the plan was provided to the resident as specified in the plan.

a) The plan of care for resident #001, indicated staff were to ensure the call bell was within easy reach and encourage resident to call for assistance. The plan also indicated the resident had an individualized call bell. On a specific date in 2013, the resident was observed in their bedroom and indicated the need to use the bathroom,

but was unable to find the call bell. The resident's individualized call alert was found on the bathroom counter. Staff confirmed the call alert should be accessible to the resident at all times.

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident.

a) In 2012, an identified registered staff, on orientation, administered medication to the wrong resident. The home confirmed the medication incident was an administration error which occurred because the staff member was new to the home and unfamiliar with the residents. Staff confirmed the resident was not wearing an identification wrist band on the date of the incident and that the supervising staff member was not present when the drugs were administered. [s. 131. (1)]

2. The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

a) In 2013, the physician ordered a change in medication for resident #001. The order specifically directed staff to change the medication dosage. Registered staff interpreted the order incorrectly. The resident missed a number doses of the medication as a result of the error. This information was verified by the Director of Resident Care (DRC). [s. 131. (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 no drugs are administered to residents unless the drugs are prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 9th day of October, 2013

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

Ministry of Health and Long-Term Care

Ministère 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 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) :	GILLIAN TRACEY (130)
Inspection No. / No de l'inspection :	2013_105130_0029
Log No. / Registre no:	H-000560-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 8, 2013
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

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that Policy 7-2 Medication Reconciliation section 7 Admission/Discharge/Transfer of Residents, is complied with.

Grounds / Motifs :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system was complied with. The home's Policy 7-2 Medication Reconciliation Section 7, Admission/Discharge/Transfer of Residents, indicated that reconciliation was to be completed: At the time of admission or readmission to the long term care facility and following a consultation with a specialist resulting in medication changes. The medication reconciliation is a multidisciplinary process lead by the nurse. The nurse creates the Best Possible Medication History (BPMH) with information obtained from the resident, resident's family or responsible party, transferring home or hospital, Community Care Access Centre (CCAC) and previous pharmacy. Whenever possible at least two sources of information are to be used to complete the BPMH. The physician will use the information gathered in determining the admission orders. Procedure #3. Record a complete and accurate list of resident's current and preadmission medications including name, dosage,frequency and route. Include any vitamins, herbal or alternative medications, over the counter medication and supplements the resident may have been taking. Procedure #7. Contact the physician and review the list of medications in detail, obtaining an order for each one to "continue" or "discontinue". Procedure #19. Second nurse reviews all

processing steps, checks that the medications and labels received from pharmacy match written order in chart, signs and adds, date and time. Procedure #24. Procedures following specialist consultation or after dialysis: Document new orders on Medication Administration record, note any changes to previous medication regime in progress notes in resident's chart, clarify any discrepancies with attending physician.

a) In 2013, resident #002, returned to the home from a specialist appointment with new physician's orders, which required clarification. Registered staff did not clarify the order with the specialist until a later date. As a result, the resident did not receive the medication ordered by the specialist for a period of five days. The home confirmed that registered staff should have clarified the order with the attending physician as per their policy and not waited to clarify with the specialist.

b) Resident #003 was admitted for a short stay in 2012. During their temporary stay, the resident received the incorrect dosage of medication. The home confirmed that the staff did not reconcile the new medication list as per their policy and had they done so, the error would not have occurred. [s. 8. (1) (b)]

Previously issued CO September 2010, June 2011 and WN March 2012, (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2013

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

Ministére 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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(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. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that any resident, including resident #001, 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 for tissue load. The plan shall be submitted to Inspector Gillian Tracey by October 1, 2013, at Gillian.Tracey@ontairo.ca.

Grounds / Motifs :

1. The licensee did not ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

a) The plan of care for resident #001, indicated the resident was dependent on staff for repositioning. In 2013, the resident was observed in their wheelchair from approximately 1030 hours until 1500 hours. The resident was not repositioned during the observed hours. The resident stated feeling uncomfortable in the chair and verified that they had not been repositioned during the observed time frame. [s. 50. (2) (d)]

Previous WN was issued on January 2011, Previous VPC was issued on August 2011 and December 2012. (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 22, 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 8th day of October, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : GILLIAN TRACEY

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