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
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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
Sep 25, 2014	2014_306510_0019	H-000897-14	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

IRENE PASEL (510), CATHY FEDIASH (214), KELLY HAYES (583)

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): July 14, 15, 16, 17, 18, 21, 22, 23, 25, 2014 and August 6, 7 2014

During the RQI, CIS inspections were conducted for log numbers H-000716-13, H000860-13, H-000340-14, H-000341-14 and H-000547-14. As well, follow up inspections were conducted related to orders issued for log #H-000149-13, and #H-000704-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Coordinator Clinical Documentation and Informatics (CDI), Registered Dietician (RD), registered nurses, registered practical nurses, Manager Dietary/Housekeeping/Laundry, Food Service Supervisor, dietary staff, and personal support workers (PSW).

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services on all home areas, and reviewed relevant documents including but not limited to: Policies and procedures, meeting minutes, menus, staff immunization records and clinical records

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 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. r. 8. (1) The licensee did not ensure that any plan, policy, protocol, procedure,

strategy or system was complied with. O. Reg. 79/10, s. 8 (1).

A.) The Home's policy #IC04-012 (Immunization - Tetanus and Diptheria) states that any current resident will be offered the immunization if it has been greater than 10 years since the last known date of administration. This is consistent with the publicly funded immunization schedule posted on the Ministry website. The immunization records for five residents were reviewed. Three of five resident had last received tetanus/diptheria immunization more than ten years previously. The Infection Prevention and Control Nurse (IPCN) for the home confirmed these residents had not received tetanus/diptheria immunization in more than 10 years. The IPCN confirmed that a report was run and revealed five residents in the home currently require tetanus/diptheria immunization because it has been more than ten years since the last known immunization. The Homes policy on tetanus/diptheria immunization was not complied with.
B.) The Home's policy #PCS01-002, Personal Assistive Service Devices (PASD) requires that the resident using a PASD must be monitored every hour and repositioned every two hours. The plan of care for resident #102 indicated that they used a PASD. The assessment by the Occupational Therapist (OT) recommended the PASD. The Resident Assessment Inventory (RAI) coordinator and the Assistant Director of Care (ADOC) confirmed the seat belt was for positioning only and was not used as a restraint. Review of the task assignments in Point of Care (POC) revealed the times for positioning were entered every two hours and the times for the checks were entered on the alternate hour while the resident was up in the chair. This schedule, which would facilitate hourly check, was confirmed by the RAI coordinator. Review of the POC documentation revealed staff documented repositioning and check every two hours. There was no documentation of the check on alternate hours. The absence of hourly checks was confirmed by the RAI coordinator and the DOC.
The resident using a PASD was not monitored every hour. Policy #PCS01-002 was not complied with.

C.) A review of the home's policy, Medication Reconciliation (10-8), indicated that at the time of admission, the nurse was to do the following:
• Procedure #3: Record a complete and accurate list of resident's current and pre-admission medications including name, dosage, frequency and route.
• Procedure #19: Second nurse reviews all processing steps, signs and adds date and time.

1) Resident #504 was admitted to the home on a specified date. A review of the

resident's medication list that accompanied them on admission to the home, indicated that the resident was prescribed medication to be taken orally each morning and to hold this medication if the resident's vital signs met specific parameters. A review of the resident's medication reconciliation completed by the home on admission, indicated that the medication had been listed along with the frequency and route; however, the instructions to hold the medication related to assessment of vital sign parameters, had not been recorded on the resident's medication reconciliation nor was the medication reconciliation form signed, dated and time entered by the second nurse reviewing the processing steps. A review of the resident's medication administration record for a specific month identified the prescribed medication along with the frequency and route and also provided a column for the nurse to document the resident's vital signs; however, the medication administration record did not include the instructions to hold the medication if the resident's vital signs met certain parameters. On an identified date, the resident's vital signs were measured prior to the administration of the medication and were documented on the medication administration record that their vital signs met the identified parameters and that the resident had been administered this medication dose. An interview with the DRC confirmed that the resident's admission medication reconciliation form had not been recorded completely and did not contain the signature, date and time of the second nurse reviewing the processing steps.

2.) Resident #505 was admitted to the home on a specified date. A review of the resident's medication list that accompanied them on admission to the home indicated that the resident was prescribed medication, one tablet daily to be taken each evening. A review of the resident's medication reconciliation completed by the home on admission, indicated the medication one tablet daily however had a recorded administration time of 0800 hours. An interview with the DRC confirmed that the medication reconciliation form had not been completed accurately. [s. 8. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home did not ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

An allegation of abuse was received by the home on an identified date. The internal investigation notes reported that a witness to the incident reported to the Assistant Director of Resident Care (ADRC) that resident #706 incurred an injury caused when a personal support worker (PSW) pulled the transfer belt aggressively around the resident. The witness further reported that the PSW used force to position the resident. Skin assessment by the registered staff later the same day revealed an injury.

The Home's 'Summary of Actions' document stated that the investigation found the PSW roughly handled resident #706 during a transfer, causing an injury.
Internal documentation from the Administrator to the PSW confirmed the PSW was aware of the Home's Abuse and Neglect – Zero Tolerance Policy (policy #RR00-001) and that the PSW's actions were in violation of both the Long Term Care Homes Act and Regulations and the Home's Policy. The PSW was disciplined related to their treatment of resident #706. Resident #706 was not treated with respect and courtesy. [s. 3. (1) 1.]

2. The licensee did not ensure that every resident was protected from abuse.
On an identified date, resident #500 reported to the ADRC that two front line nursing staff had spoken and acted inappropriately to them and other co-resident's, on several occasions. An investigation conducted by the home indicated that one of the front line nursing staff was found to have been rude and abrupt. As well, the staff member used a demeaning tone in publicly asking humiliating questions of cognitively challenged residents and made negative comments about residents to fellow staff, within earshot of other residents. The investigation also indicated that the second front line staff member was found to have used a loud and condescending tone in speaking to cognitively challenged residents, in front of other residents and staff. The home's investigation concluded that the actions of the front line nursing staff were "abusive or neglectful and breached the provisions of both the Long Term Care Homes Act and Regulations and our own policy". [s. 3. (1) 2.]

3. The licensee of a long-term care home did not ensure that the following rights of

residents were fully respected and promoted: 3. every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

An allegation of abuse was received by the home on an identified date when a registered staff member reported they witnessed a PSW use undue force and a demanding tone of voice when asking Resident #701 to stand up from the chair. Internal investigation notes reported that Resident #701 was a two person transfer. The registered staff and PSW were assisting Resident #701 from a wheel chair onto another chair when the PSW spoke sharply to the resident and began to transfer the resident although the registered staff was not ready to assist with the transfer. The PSW forcefully pulled on the resident's left arm in spite of being asked by the registered staff to wait. There was a sign over the resident's bed directing staff to avoid forceful grabbing with left hand.

Correspondance from the Home to the PSW stated that the PSW showed neglect for the resident's safety that breached the Abuse and Neglect - Zero Tolerance Policy (Policy #RR00-001) in spite of receiving training on the policy less than 2 weeks prior to the incident. Staff showed neglect for the safety of resident #701. [s. 3. (1) 3.]

4. The licensee did not ensure that the rights of residents to be cared for in a manner consistent with his or her needs, was fully respected and promoted.

A review of resident #507's clinical record indicated that they had been assessed as requiring extensive assistance of two staff for all of their transfer needs. A review of the resident's clinical record along with the home's submitted critical incident indicated that the resident had sustained a fall on an identified date, during a transfer from a seated position to their walker, with the assistance of only one staff. As a result of the fall, the resident sustained a laceration to the back of their head, transfer to hospital and a significant change in their health condition. The home's investigation into the incident indicated that the staff member that was involved in the transfer of the resident was aware of the resident's needs to have two staff provide extensive assistance during the residents transfers; however, had transferred the resident alone. An interview conducted with the DRC confirmed that the resident had not been cared for in a manner consistent with their needs. [s. 3. (1) 4.]

5. The licensee did not ensure that every residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Registered staff confirmed that medication packages, which contained residents' names and medication regimes, were discarded with the general garbage and not disposed of in a manner which would ensure that the residents' personal health information was protected. [s. 3. (1) 11. iv.]

Additional Required Actions:

CO # - 002 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 , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) 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; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods were served using methods which preserved nutritive value.

A) On an identified date lunch was observed on an identified home area. Residents were shown two show plates one of which contained half an egg salad sandwich with caesar salad. All residents who requested an egg salad sandwich received half a sandwich. A review of regular recipe showed the required serving for the regular diet was one full sandwich. The manager of Dietary/Housekeeping/Laundry confirmed that the residents did not receive the planned serving of the egg salad sandwich and that it provided half the calories and protein required per the nutritional requirements of the Niagara Region Summer Menu 2014.

B) On an identified date lunch was observed in identified dining rooms. Five residents were observed to receive 125ml of milk in the dining room at 1210 hours. A review of the menu indicated residents on a regular diet should have received 250ml of milk with lunch. The manager of Dietary/Housekeeping/Laundry met with the inspector on an identified date and observed the dining rooms during lunch service. The manager of Dietary/Housekeeping/Laundry verified that greater than 50 percent of the residents received a half portion of milk and the milk provided half the calories and protein required per the nutritional requirements of the Niagara Region Summer Menu 2014.

C) On an identified date dinner was observed in the dining room of an identified home area. Residents were shown two show plates one of which contained a small portion of oven baked chicken, potato salad and Scandinavian vegetables. All residents who requested the oven baked chicken received one small bone in chicken thigh. The chicken thigh with bone in was weighed using the scale by the manager of Dietary/Housekeeping and measured 56 grams. The 56 gram piece of bone in chicken thigh provided 108 calories and 11 grams of protein. A review of the "Nutritional Breakdown Niagara Region Summer Menu 2014 Menu Regular" indicated the chicken should have yield 241 calories and 21 grams of protein. It was confirmed with the dietary aides that residents in the identified dining rooms who chose the baked chicken received one chicken thigh bone in weighing approximately 55 grams. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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,
(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; O. Reg. 79/10, s. 50 (2).

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff.

A.) In a review of the plan of care and through an interview with the registered staff it was identified that resident #106 had an open surgical wound and a stage 2 pressure ulcer. The open surgical wound and the stage two pressure ulcer were initially

assessed on identified dates and it was verified with registered staff that both altered skin areas had remained unhealed. A review of the plan of care showed that a weekly skin assessment of the surgical wound and the pressure ulcer had not been completed weekly during identified time periods. It was verified with registered staff that the expectation was that the Point Click Care weekly skin assessment tool was to be completed weekly for all altered skin integrity and that resident #106 did not receive weekly skin assessment during an identified time period.
B.) In a review of the plan of care and through an interview with the registered staff it was identified that resident #101 had a chronic open surgical wound. A review of the plan of care during a specified time period showed that a weekly skin assessment of the wound was not completed weekly. It was verified with registered staff that the expectation was that the Point Click Care weekly skin assessment tool was to be completed weekly for all altered skin integrity and that resident #101 did not receive a weekly skin assessment during a specified time period. [s. 50. (2) (b) (iv)]

2. The licensee did not ensure that any resident who is 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 #501 indicated that the resident was dependent on staff for repositioning. On a specified date, the resident was observed in their wheelchair from approximately 0950 hours until 1330 hours. The resident was not repositioned during the observed hours. Interviews conducted with front line nursing staff confirmed that the resident was required to be repositioned every two hours and that the resident had not been repositioned since the start of their shift, which commenced at 0700 hours.
B.) The plan of care for resident #503 indicated that the resident was dependent on staff for repositioning. On a specified date, the resident was observed in their wheelchair from approximately 0950 hours until 1320 hours. The resident was not repositioned until 1320 hours, which was a period of three and one half hours, from the time observed. Interviews conducted with front line nursing staff confirmed that the resident required repositioning every two hours and had not been repositioned every two hours. [s. 50. (2) (d)]

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 be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the menu cycle included alternate choices of vegetables at lunch.

During the lunch dining service on a specified date in an identified dining room it was observed that residents were offered and received the the same vegetable blend (corn, peas, carrots and beans) for both lunch choices. The menu described the two choices as home style blend vegetables and marinated vegetable salad. It was confirmed with with Dietary Aid and the Food Service Supervisor the same vegetables were served for both choices and that one was served hot and the other was served as a cold marinated salad. [s. 71. (1) (c)]

2. The licensee did not ensure the menu cycle was approved by a registered dietitian (RD) who was a member of the staff of the home.

In an interview with the manager of Dietary/Housekeeping/Laundry on an identified date it was confirmed that the new Spring Summer 2014 menu had started in the home on June 22, 2014. In a phone interview with the Registered Dietician (RD) on July 17, 2014 it was verified that the RD had not yet received, reviewed or signed off the Spring Summer 2014 menu. [s. 71. (1) (e)]

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 be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there were schedules and procedures in place for routine, preventative and remedial maintenance.

A tour conducted throughout the home on specified dates indicated that out of 35 resident rooms observed, 25 of these resident rooms were identified as having various stages of disrepair. The rooms were identified on four out of five units and included room #'s 2101, 2108, 2110, 2141, 2205, 2208, 2210, 2215, 2219, 2226, 2230, 3101, 3104, 3105, 3115, 3119, 3128, 3136, 3137, 3201, 3208, 3214, 3219, 3228 and 3239. The disrepair was noted to the walls which included scrapes and gouges in the drywall to bathroom walls and resident room walls, particularly behind the bed and the corners of the walls; chipped paint to bedroom and bathroom walls; scuff marks of varying degrees to bedroom and bathroom walls. Five out of five units toured, indicated various stages of disrepair to the walls and ceilings in the common areas, which included rippled paint, chipped paint and gouges to the drywall at the end of hallways; chipped paint to the ceiling in the nursing stations; scrapes to the wall outside of the Bayview Heights nursing station and a hole in the drywall on the Lakeside Gardens unit hallway. Tours of the above areas were conducted with the Administrator and maintenance staff, who confirmed that they were aware of the disrepair. The maintenance staff indicated that annually, the home's interior walls were inspected and repaired as necessary and that maintenance requests were completed by the staff when disrepair was noted. These maintenance requests were entered into an electronic data base and assigned as "projects". The maintenance staff indicated that the home completed their "core assignments" first and that projects were completed when time permits. Staff also confirmed that the home did not have a schedule or procedure in place to complete the routine maintenance of the home's interior walls. [s. 90. (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 be implemented voluntarily.

WN #7: 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. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) Resident #504 was admitted to the home on a specified date. A review of the resident's medication list that accompanied them on admission to the home, indicated that the resident was prescribed medication to be taken orally each morning and to hold this medication if the resident's vital signs met specific parameters. A review of the resident's medication administration record for a specific month identified the prescribed medication along with the frequency and route and also provided a column for the nurse to document the resident's vital signs. However, the medication administration record did not include the instructions to hold the medication if the resident's vital signs met specific parameters. On an identified date, the resident's vital signs were measured prior to the administration of the medication and were documented on the medication administration record that their vital signs met specific parameters and that the resident had been administered this medication dose . An interview with the Director of Care (DRC) confirmed that the resident's prescribed medications were not administered to the resident in accordance with the directions for use specified by the prescriber.

B) Resident #505 was admitted to the home on an identified date. A review of the resident's medication list that accompanied them on admission to the home indicated that the resident was prescribed a medication one tablet daily to be taken each evening. A review of the resident's electronic medication administration record identified the medication of one tablet daily had a recorded administration time of 0800 hours. An interview with the DRC confirmed that the residents prescribed medications were not administered to the resident in accordance with the directions for use specified by the prescriber. [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 be implemented voluntarily.

WN #8: 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. (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 the plan of care set out clear directions to the staff and others who provided direct care to the residents.

Resident #103 was observed wearing a split back adaptive t-shirt on an identified date, a non-button loose fitting blouse on an identified date, and a split back adaptive t-shirt on an identified date. A review of the plan of care including the Kardex and Care Plan did not identify that resident #103 required adaptive clothing. In an interview with registered staff it was shared that the resident did not wear adaptive clothing as per the plan of care. In a subsequent interview with registered staff and non-registered staff it was identified that resident #103 wore both regular clothing and adaptive clothing. In an interview with resident #103 it was verified that their preference was to wear some adaptive clothing as well as loose fitting clothing with easy to handle fasteners because of discomfort with dressing caused from an old injury. Staff confirmed the plan of care did not set out clear direction for dressing resident #103. [s. 6. (1) (c)]

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

A.) The written plan of care for resident #501 indicated that the resident required extensive assistance of two staff for their dressing needs. On an identified date, just prior to the lunch hour, the resident was observed to have had their shirt changed with the assistance of one staff. An interview conducted with the front line nursing staff involved in this observation, confirmed that the resident's plan of care did require the assistance of two staff for dressing and that they had performed this task alone.

B.) The written plan of care for resident #501 indicated that the resident required the use of a personal assistance services device (PASD). The written plan of care indicated that while the PASD was in use, staff were required to check the PASD hourly to ensure that it was in the proper position and to release the PASD, reposition the resident and reapply the PASD, if required, every two hours. On August 6, 2014, the resident was observed from approximately 0950 hours until 1330 hours, with the PASD in use. The PASD was not checked hourly to ensure proper positioning, nor was the PASD released and the resident repositioned every two hours, during the observed hours. An interview conducted with front line nursing staff confirmed that the resident's plan of care did require their PASD to be checked hourly and that every two hours, the PASD was to be released, the resident repositioned and the PASD reapplied, if necessary and that this had not been completed on their shift, which commenced at 0700 hours. [s. 6. (7)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents set out the consequences for those who abused or neglected residents.

The home's policy, Abuse and Neglect-Zero Tolerance (RR00-001), indicated under the actions, "Most Senior Manager Responsible or On-Duty or On-Call (e.g. Administrator, Director of Resident Care (DRC), or Alternative), that the Administrator may be required to notify relevant Professional College, if applicable and determine the appropriate management action(s) to be taken as a result of the findings of investigation (e.g. education, discipline, policy revision, mandatory reporting to relevant professional college). The DRC confirmed that the policy only included consequences for registered staff who abuse or neglect residents, not for non-regulated staff who abuse or neglect residents. [s. 20. (2) (f)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's sleep patterns and preferences.

A review of the plan of care for resident #108 did not include the identification of the resident's sleep patterns and preferences with regards to waking in the morning or rest periods throughout the day. An interview conducted with registered staff confirmed that the resident's plan of care did not include this information. [s. 26. (3) 21.]

WN #11: 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 did not ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) The quarterly minimum data set (MDS) completed for resident #109 on a specified date, indicated that the resident was occasionally incontinent of bladder. The annual MDS completed for this resident on an identified date, indicated that the resident was frequently incontinent of bladder. The clinical documentation and informatics (CDI) coordinator confirmed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had changed.
B) The annual MDS completed for resident #111 on an identified date, indicated that the resident was frequently incontinent of bowel. The quarterly MDS completed for this resident on on an identified date, indicated that the resident was occasionally incontinent of bowel. The CDI Coordinator confirmed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had changed. [s. 51. (2) (a)]

WN #12: 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:
1. Communication of the seven-day and daily menus to residents. 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that weekly menus were communicated to the residents.

During tour on an identified date of specified home areas it was observed that the weekly menus posted for the residents were 'Week 2 Spring Summer 2013'. The daily menu advertised on the television screens did not match the posted weekly menu. It was confirmed with the Manager of Dietary/Housekeeping/Laundry that weekly menu was Week 3 of the Spring Summer menu, that they were using the 2013 menu and had not made changes for 2014. Therefore it was confirmed that the correct weekly menu was not communicated to the residents. [s. 73. (1) 1.]

2. The licensee did not ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

During lunch service observation on identified home areas residents were served BLT sandwiches with french fries as one of the lunch choices. In an interview with resident #111, #600 and #601, they shared that the french fries were cold. Resident #601 also described the fries as soggy. At 1230 hours while dietary aides were still serving entrees, inspector #583 tasted the french fries and they were cold and oily. In an interview with the cook it was verified the fries were made at 11:40hours. In an interview with the Manager of Dietary/Housekeeping/Laundry and the Food Service Supervisor it was shared that they assumed it would be difficult to maintain the temperature and palatability of french fries. [s. 73. (1) 6.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not ensure that they sought the advice of Residents' Council and Family council in developing and carrying out the survey, and in acting on its results.

In an interview with the resident council and family council presidents, it was identified that the home did not seek the councils advice in the development or carrying out of the survey. The results were shared with the councils but they were not involved in decision making as to what actions were taken as a result of the survey. It was confirmed with the resident council assistant and the Administrator that both councils were only informed of the survey results. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

A.) CI number M610-000004-14 submitted on an identified date reported that the substitute decision maker (SDM) was not notified of the outcome of the investigation into the incident of alleged abuse.
On an identified date, the director of resident care (DRC) and associate director of resident care (ADRC) confirmed that the SDM of resident #702 was not notified of the results of the investigation into the allegations of abuse.

B.)On an identified date, resident #500 reported to the ADRC that two front line nursing staff had spoken and acted inappropriately to them and other co-resident's, on several occasions. An investigation conducted by the home indicated that one of the front line nursing staff was found to have been rude, abrupt and used a demeaning tone in publicly asking humiliating questions of cognitively challenged resident's and that this staff member also made negative comments about residents to fellow staff, within earshot of other resident's. The investigation also indicated that the second front line staff member was found to have used a loud and condescending tone in speaking to cognitively challenged residents, in front of other residents and staff. The home's investigation concluded that the actions of the front line nursing staff were "abusive or neglectful and breach the provisions of both the Long Term Care Homes Act and Regulations and our own policy". An interview conducted with the Assistant Director of Care (ADRC) confirmed that resident #500 was not notified of the results of the investigation, immediately upon the completion of the investigation. [s. 97. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A.) A review of the medication regime for resident #106 indicated that they were prescribed a routine controlled substance medication by mouth at 0800 hours and 1200 hours and one tablet by mouth at supper. It was observed that this routine controlled substance medication was dispensed in a medication package that also contained a non-controlled medication and that the medication package was stored inside the medication cart in an area that was not a separate locked area. An interview with registered staff, and confirmed by the DRC, indicated that routine prescribed controlled substances were not stored in a separate locked area within the locked medication cart.

B.) An interview with Registered Staff confirmed that routine prescribed controlled substances were dispensed into medication packages with routine prescribed non-controlled substances and that when a controlled substance in the medication package was discontinued or had a change in direction, the Registered Staff would remove this medication package and place it in an open bin that was located on the counter in the locked medication room. These routine controlled substances would remain in the open bin for an undetermined length of time until the bin was full and at that time, would be moved to the Port Place medication room and stored until drug destruction took place. An interview with the DRC confirmed that this was the practice of the home and that controlled substances were not stored in a separate, double-locked stationary cupboard within the locked medication storage room. [s. 129. (1) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure the security of the drug supply, including the following: A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action is taken if any discrepancies are discovered.

An interview with Registered Staff revealed that routine prescribed controlled substances were dispensed into medication packages with routine prescribed non-controlled substances and that these routine prescribed controlled substances were not counted as part of the daily count sheets of controlled substances and consequently, were not part of the monthly audit to determine if any discrepancies had occurred. This was confirmed by the DRC. [s. 130. 3.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

During a tour of the home on specified dates, it was observed outside an identified room that an isolation cart containing personal protective equipment of gloves, gowns and masks was present. No precaution signage was posted at this resident's room to advise what precautions were to be taken. An interview with the Niagara Regional Infection Prevention and Control Nurse, confirmed that a contact precaution sign should have been posted on the resident's door. [s. 229. (4)]

Issued on this 19th day of October, 2014

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

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

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) :	IRENE PASEL (510), CATHY FEDIASH (214), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2014_306510_0019
Log No. / Registre no:	H-000897-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 25, 2014
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)

Linked to Existing Order / Lien vers ordre existant: 2013_105130_0029, CO #001;

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
1. an audit of no fewer than 3 residents on each home area is conducted
2. results of the audit and remedial action taken to facilitate compliance are submitted by November 10, 2014 to cathy.fediash@ontario.ca

Grounds / Motifs :

1. A review of the home's policy, Medication Reconciliation (10-8), indicated that at the time of admission, the nurse was to do the following:

• Procedure #3: Record a complete and accurate list of resident's current and preadmission medications including name, dosage, frequency and route.
• Procedure #19: Second nurse reviews all processing steps, signs and adds date and time.

A) Resident #504 was admitted to the home on an identified date. A review of the resident's medication list that accompanied them on admission to the home, indicated that the resident was prescribed medication to be taken orally each morning and to hold this medication if the resident's vital signs met specific parameters. A review of the resident's medication reconciliation completed by the home on admission, indicated that the medication had been listed along with the frequency and route, however, the instructions to hold the medication if the

resident's vital signs met specific parameters, had not been recorded on the resident's medication reconciliation nor was the medication reconciliation form signed, dated and time entered by the second nurse reviewing the processing steps. A review of the resident's medication administration record for a specified month identified the prescribed medication with the frequency and route and also provided a column for the nurse to document the resident's vital signs; however, the medication administration record did not include the instructions to hold the medication if the resident's vital signs met specific parameters. On a specified date, the resident's vital signs were measured prior to the administration of the medication and was documented on the medication administration record that their vital signs met specific parameters and that the resident had been administered this dose of medication. An interview with the DRC confirmed that the resident's admission medication reconciliation form had not been recorded completely and did not contain the signature, date and time of the second nurse reviewing the processing steps.

B) Resident #505 was admitted to the home on an identified date. A review of the resident's medication list that accompanied them on admission to the home indicated that the resident was prescribed medication to be taken each evening. A review of the resident's medication reconciliation completed by the home on admission, indicated the daily medication dose, however had a recorded administration time of 0800 hours. An interview with the DRC confirmed that the medication reconciliation form had not been completed accurately.

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure all residents are cared for in a manner consistent with their needs.

Grounds / Motifs :

1. An allegation of abuse was received by the home on an identified date. The internal investigation notes reported that a witness to the incident reported to the Assistant Director of Resident Care (ADRC) that a resident incurred an injury caused when a PSW pulled the transfer belt aggressively around the resident. The witness further reported that the PSW used physical force to position the resident. Skin assessment by the registered staff later the same day revealed an injury.

The Home's Summary of Actions document stated that the investigation found the PSW roughly handled a resident during a transfer, causing an injury to the resident.
Internal documentation from the Administrator to the PSW confirmed the PSW was aware of the Home's Abuse and Neglect – Zero Tolerance Policy (policy #RR00-001) and that the PSW's actions were in violation of both the Long Term Care Homes Act and Regulations and the Homes Policy. The PSW was disciplined related to their treatment of resident #706. (510)

2. A review of resident #507's clinical record indicated that they had been assessed as requiring extensive assistance of two staff for all of their transfer needs. A review of the resident's clinical record along with the home's submitted critical incident indicated that the resident had sustained a fall on an identified date, during a transfer with the assistance of only one staff. As a result of the fall, the resident sustained an injury, transfer to hospital and a significant change in their health condition. The home's investigation into the incident indicated that the staff member that was involved in the transfer of the resident was aware of the resident's needs to have two staff provide extensive assistance during the residents transfers, however had transferred the resident alone. An interview conducted with the DRC confirmed that the resident had not been cared for in a manner consistent with their needs. (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) 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; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall ensure that all meals and portions provided to the residents as per the planned menu are the same as the Registered Dietician approved "Nutritional Breakdown Niagara Region Summer Menu 2014" and provide adequate nutrients, fibre and energy.

Grounds / Motifs :

1. A) On an identified date lunch service was observed on a specified home area. Residents were shown two show plates one of which contained half an egg salad sandwich with Caesar salad. All residents who requested an egg salad sandwich received half a sandwich. A review of regular recipe showed the required serving for the regular diet was one full sandwich. The manager of Dietary/Housekeeping/Laundry confirmed that the residents did not receive the planned serving of the egg salad sandwich and that it provided half the calories and protein required per the nutritional requirements of the Niagara Region Summer Menu 2014.

B) On an identified date lunch was observed in identified dining rooms. Five residents were observed to receive 125ml of milk. A review of the menu indicated residents on a regular diet should have received 250ml of milk with lunch. The manager of Dietary/Housekeeping/Laundry met with the inspector on the same date and place and observed lunch service. The manager of Dietary/Housekeeping/Laundry verified that greater than 50 percent of the residents received a half portion of milk and the milk provided half the calories and protein required per the nutritional requirements of the Niagara Region Summer Menu 2014.

C) On an identified date, dinner was observed in an identified dining room. Residents were shown two show plates one of which contained a small portion of oven baked chicken, potato salad and Scandinavian vegetables. All residents who requested the oven baked chicken received one small bone in chicken thigh. The chicken thigh with bone in was weighed using the scale by the manager of Dietary/Housekeeping and measured 56 grams. The 56 gram piece of bone in chicken thigh provided 108 calories and 11 grams of protein. A review of the "Nutritional Breakdown Niagara Region Summer Menu 2014 Menu Regular" indicated the chicken should have yield 241 calories and 21 grams of protein. It was confirmed with the dietary aides that residents in the identified dining rooms who chose the baked chicken received one chicken thigh bone in weighing approximately 55 grams. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2014

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

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

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 25th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Irene Pasel

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