Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2020	2020_829757_0005	019419-19, 019438-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way 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

DAVID SCHAEFER (757)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 3-6, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:
- Two intakes, log #019419-19 and log #019438-19, related to two residents' falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident, followed by the report required under subsection (4).

A Critical Incident System (CIS) report was submitted to the Director by the home's Director of Resident Care (DRC), related to an accident involving resident #001, which resulted in the resident sustaining an injury, and subsequently being transferred to hospital.

The CIS report was last amended seven days following the initial report, to include information indicating that resident #001 had received an intervention related to an injury

sustained from the accident, and had since returned to the home.

A review of resident #001's electronic assessments identified that a specific assessment had been completed for the resident, on the same day the last CIS report amendment had been submitted. The assessment resulted in a score which indicated that the resident had experienced a significant decline in their health status.

The Inspector conducted a review of resident #001's electronic progress notes. The notes indicated that the resident had been transferred back to hospital, the day after the last CIS report amendment had been submitted, due to a deterioration in their condition, and had subsequently passed away.

A review of the Ministry of Long-Term Care's "Long Term Care Homes Portal" (ltchomes.net) identified that no further CIS report amendments, and no additional report had been submitted to inform the Director of resident #001's deterioration following the accident and transfer back to hospital.

During an interview with the DRC, they stated that the resident had declined following the incident due to complications related to their injury, before being transferred back to hospital and passing away. The DRC confirmed that the resident's death had not been reported to the Director. [s. 107. (1) 2.]

2. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1) of Ontario Regulation (O. Reg.) 79/10, the licensee made a report in writing to the Director setting out the outcome or current status of the individual who was involved in the incident.

A CIS report was submitted to the Director by the DRC, related to an incident involving resident #002, which resulted in an injury. The report indicated that when the resident was assessed following the incident, they had complained of an injury to a specific area of their body. The report made no mention of any additional injuries sustained to the resident as a result of the incident.

A review of an assessment completed for resident #002 following this incident identified that the resident had sustained an additional injury to another specific area of their body, which had not been indicated in the CIS report.

The Inspector conducted an interview with the DRC, who confirmed they had not

included resident #002's current status related to their additional injury at the time they submitted their initial CIS report to the Director, or at any time thereafter. [s. 107. (4) 3. v.]

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 that ensures that: the Director is immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide; and when required to inform the Director of an incident under subsection (1), (3) or (3.1) of Ontario Regulation 79/10, the licensee makes a report in writing to the Director setting out the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #2: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on the needs of resident #002.

A review of resident #002's current care plan with a specific focus, indicated that staff were to implement an intervention, while the resident was in bed.

The Inspector conducted an observation of resident #002's room while the resident was sleeping in bed. The Inspector noted that the intervention had not been implemented as specified in the resident's care plan intervention.

The Inspector conducted an interview with Personal Support Worker (PSW) #104 in resident #002's room, where they confirmed that the intervention had not been implemented.

During an interview with Registered Practical Nurse (RPN) #105, the RPN stated that resident #002's needs required the intervention to be implemented in the resident's room, while the resident was sleeping in bed.

The Inspector conducted an interview with the DRC, who confirmed that resident #002's needs required a specified intervention in their room, and stated staff were expected to implement the intervention, while the resident was in bed. [s. 6. (2)]

WN #3: 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 has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with Ontario Regulation (O. Reg.) 79/10, s. 48 (1) 1., and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, which provided strategies to monitor residents.

Specifically, staff did not comply with the home's policy titled "Post Fall Assessment – PCS04-011". The policy stated that when a resident had fallen, staff were to initiate a Glasgow Coma Scale (GCS) if the resident sustained a head injury, when the fall was unwitnessed, or when otherwise warranted.

During an interview with Registered Nurse (RN) #103, they stated that a GCS assessment was to be initiated following unwitnessed falls, and that this assessment was included in the electronic Head Injury Routine (HIR) assessment.

The Inspector reviewed resident #002's electronic records, which identified that the resident had a fall. An electronic post-fall assessment identified that the fall was unwitnessed; however, the record review found no documentation related to a GCS or HIR assessment being initiated following the fall.

The Inspector conducted an interview with RPN #105, who had initially responded to resident #002's fall. The RPN confirmed that they had not completed a GCS assessment following the unwitnessed fall. The RPN stated they should have completed the GCS assessment following the fall, according to the home's policy.

During an interview with the DRC, they stated it was the home's policy that when a resident had an unwitnessed fall, staff were required to complete a GCS assessment. The DRC confirmed that staff had not assessed the resident according the home's "Post Fall Assessment" policy, following this fall. [s. 8. (1) (b)]

Issued on this 18th day of February, 2020

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

Original report signed by the inspector.