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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 15, 2020 | 2020_848748_0005 | 004284-20, 004341-20, 009414-20, 015666-20, 022838-20, 023309-20 | 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

EMMY HARTMANN (748), LISA BOS (683)

## 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): November 30, December 1, 2, 3, 4, and 7, 2020.**

**The following intakes were completed during this inspection:**

**Log #004284-20 was related to a fall with injury.**
**Log #004341-20 was related to a fall with injury.**
**Log #009414-20 was related improper or incompetent care of a resident.**
**Log #015666-20 was related to missing or unaccounted for controlled substance.**
**Log #022838-20 was related to a fall with injury.**
**Log #023309-20 was related to a fall with injury.**

**This inspection was completed concurrently with Complaint Inspection #2020_848748_0004.**

**During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Resident Care (ADRC), RAI-Coordinator, registered practical nurses (RPN), and personal support workers (PSW).**

**During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Medication**
**Personal Support Services**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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 failed to ensure that a resident's plan of care was followed related to the application of an assistive device while the resident was transported or assisted in their mobility device.

A review of the resident's written plan of care identified that they were totally dependent on one staff for locomotion. Their care plan identified that staff were to ensure that the assistive device was applied to the resident's mobility device prior to transporting and/or assisting the resident.

The resident's progress notes revealed that in May 2020, the resident sustained an injury as a result of not having their assistive device applied to their mobility device while a staff member was assisting them.

RPN #113 identified that the resident was supposed to have their assistive device applied to their mobility device, and that their plan of care was not followed.

There was minimal risk related to this non-compliance as the resident sustained an injury, as a result of their plan of care not being followed.

Sources: Review of a resident's progress notes, and care plan; Interview with RPN #113. [s. 6. (7)]

***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 #2: 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 home failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with Ontario Regulation 79/10, s.114(2), the written policies and protocols were to be developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home's Narcotic and Controlled Substances Policy, which stated that when narcotics or controlled substances were received from the pharmacy, the registered staff member must count the medication to ensure the appropriate amount was sent by the pharmacy; and that all narcotics and controlled substances must be counted at the beginning of every shift by two Registered Staff members (outgoing and incoming) counting the actual number of remaining medications.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) in July 2020, to report five missing or unaccounted for, vials of a controlled substance.

A review of the home's investigation notes identified that the home completed an investigation into this incident and spoke with the nurses involved. The nurses did not physically open the box of the medication to confirm the actual amount in the box when the medication was received from pharmacy; and also did not physically open the box during the shift change count on the evening shift prior to discovering they were missing. The medication was noted to be missing on the shift change count on an identified date in July 2020 in the morning shift. The DOC identified that staff did not follow the home's policy where they needed to confirm the actual amount received.

There was minimal risk related to this non-compliance as having an inaccurate count of the supply on-hand, placed the resident at risk of not receiving their required medication.

Sources: Review of CIS report, review of the home's investigation notes; Interview with Director of Care. [s. 8. (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 ensure that 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 plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.***

---

**WN #3: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed no later than one business day, after the occurrence of a missing or unaccounted for controlled substance.

The home submitted a CIS report to the MLTC on an identified date in July 2020, to report a missing or unaccounted for, controlled substance that was prescribed to a resident.

A review of the resident's progress notes identified that they were prescribed the medication, as they were on Palliative Care. A review of the home's investigation notes identified that the home became aware of the missing medication on an identified date in July 2020. The home started their investigation of the incident but they did not report the occurrence to the MLTC until nine days later.

Sources: Review of CIS report, review of the home's investigation notes; Interview with Director of Care. [s. 107. (3)]

---

**Issued on this 29th day of December, 2020**

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

**Original report signed by the inspector.**