Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 23, 2023

Inspection Number: 2023-1605-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: Northland Pointe, Port Colborne

Lead Inspector	**Inspector Digital Signature**
Emily Robins (741074)	Emily C Robins Digitally signed by Emily C Robins Date: 2023.07.17 12:38:20 -04'00'

Additional Inspector(s)
Erin Denton-O'Neill (740861)
Jonathan Conti (740882)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2-5, 8-12, 15-17, 19, 24-26, 2023.

The following intakes were inspected in this inspection:

- Intake #00001032 related to a controlled substance missing/unaccounted for.
- Intake #00002355 related to a controlled substance missing/unaccounted for.
- Intake #00004110 related to a resident experiencing severe hyperglycemia.
- Intake #00007690 related to neglect and emotional abuse of a resident.
- Intake #00018248 related to a resident's partial upper denture becoming dislodged. Related to intake #00018249.
- Intake #00019142 related to the unexpected death of a resident. Related to intake #00016785.
- Intake #00019968 - complainant with concerns related to plan of care, skin and wound care and pain management. Related to intake #00018248.
- Intake #00084470 related to fall of resident resulting in a fracture.

The following intakes were completed in this inspection:

Intake #00006595 related to a controlled substance missing/unaccounted for (related to intakes #011338 and #011852) and intakes #00012713, #00016785 (related to intake 00012713), and #00016992 all related to resident falls resulting in fracture.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that the rights of a resident were fully respected and promoted as follows: every resident has the right to proper care and services consistent with their needs.

Rationale and Summary

In April 2022 a resident with diabetes developed severely high blood sugar levels. A Physician's order was obtained for insulin to be given every night starting the following night however, was not processed until three days after it was initially ordered. Failure to process this order in a timely manner resulted in the resident experiencing sustained high blood sugar readings, putting them at risk for worsening of symptoms and associated complications.

Sources: Resident's progress notes, blood sugar log and electronic medical administration record for April 2022, the home's investigation package for CI # M610-000014-22, joint interview with Directors of

Resident Care (DRC), and interview with Substitute Decision Maker (SDM). [741074]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

A) The licensee has failed to ensure that the provision of care was documented as set out in the plan of care for a resident.

Rationale and Summary

A resident who required extensive assistance with toileting was on a scheduled toileting program as per their plan of care at the time of an unwitnessed fall in their washroom in 2022.

This task was to be documented in Point of Care (POC) by the Personal Support Worker (PSW). A member of the management team confirmed that there was no documentation of this task the day of their unwitnessed fall at 1400, 1800, and 2000 hours.

Failure to document whether care was provided posed the risk that it may not have been provided as per their plan of care.

Sources: Critical Incident M610-000042-22; resident care plan, task documentation, progress notes, physical chart; internal investigation notes; interviews with PSWs, Infection Prevention and Control (IPAC) Lead, DRC. [740882]

B) The licensee has failed to ensure that the provision of oral care as set out in the plan of care for a resident was documented.

Rational and Summary

A Resident's January 2023 Documentation Survey Report indicated that they were to receive oral care twice daily (morning and evening) as per ministry standards. However, nine times on morning shift and four times on evening shift provision of oral care was not documented. The DRC confirmed this.

Failure to document whether oral care was provided put the resident at risk of not receiving adequate care by reducing accountability of staff providing the care.

Sources: Resident's Documentation Survey Report from January 2023 and interview with DRC. [741074]

C) The licensee has failed to ensure that the provision of care, specifically adherence to a resident's toileting program as set out in their plan of care was documented.

Rationale and Summary

In January of 2023 a resident was incontinent of bowel, and frequently incontinent of bladder. They were on a scheduled toileting plan to promote continence and they used briefs or pads. The resident's care plan indicated that they were to be toileted as per their POC toileting schedule.

This resident's Documentation Survey Report for January 2023 indicated that care related to toileting was not documented 14 times. Their documentation survey report for February 2023 indicated that care related to toileting was not documented 29 times. Their documentation survey report for March 2023 indicated that care related to toileting was not documented nine times. This was confirmed by the RPN.

Failure to document care related to toileting put this resident at risk of not receiving adequate care by reducing the level of accountability from staff to provide this care.

Sources: Resident Assessment Instrument Material Data Set for January 2023, Care Plan and Documentation Survey Reports January-March 2023, and interview with RPN. [741074]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care for a resident were documented.

Rationale and Summary

A resident's Documentation Survey Report indicated that a PSW performed total oral care on them during morning care on a specific day in January 2023.

Later in an interview, this PSW indicated that when they attempted to perform oral care that morning, the resident refused. They admitted that they should not have documented that they performed total oral care on the resident because they had not.

Failure to accurately document the outcome of the oral care provided to this resident, specifically that oral care was refused not provided, may have diminished the quality of communication amongst the team and put the resident at risk of not receiving care as planned by reducing staff accountability.

Sources: Resident's Documentation Survey Report for January 2023 and interview with PSW. [741074]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was protected from neglect by a Personal Support Worker (PSW).

Rationale and Summary

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Specifically, on a day in May 2022 a resident was toileted on a commode by a PSW. The resident had an intervention in their plan of care for extensive assistance with two-person assistance required for safety when toileting. The resident, PSW, and Administrator confirmed that only one PSW had provided transfer assistance for the resident.

The PSW then left the resident on the commode, not returning for over 40 minutes. The resident was emotionally distraught and recalled that they were scared and shaking. The resident was unable to be heard from the bathing suite when attempting to call for help. The resident was unable to call for assistance as they were not provided with a call bell by the PSW before they left. The plan of care for this resident specified that staff were to ensure a call bell was within reach at all times and that they were to be encouraged to use the call bell.

Staff jeopardized the safety and well-being of this resident by failing to provide appropriate transfer assistance, not providing a call bell for the resident, and leaving the resident unsupervised on the commode.

Sources: Interviews with resident, staff; Critical Incident Report M610-000015-22; resident's care plan, progress notes, assessments; internal investigation notes; staff disciplinary letter, training

records. [740882]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure immediate reporting to the Director of the suspected neglect of a resident that resulted in risk of harm.

Rationale and Summary

A Critical Incident (CI) report was submitted in relation to an incident of alleged neglect the following day on which it occurred. The home was made aware of the incident on the day it occurred, and the Administrator acknowledged that the incident was not immediately reported to the Director through the after-hours line.

Sources: Interviews with resident, staff; Critical Incident Report M610-000015-22; internal investigation notes; staff disciplinary letter. [740882]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.

The licensee has failed to ensure that where the Act or this Regulation required, the licensee of a long-term care home reported to the Director a missing or unaccounted for controlled substance no later than one business day after the incidence.

Rationale and Summary

On a day in May 2022, a RPN disposed of a controlled substance in the garbage and reported this to the RN in June 2022. The patch was to be placed in the narcotic disposal bin and it was not found there. The controlled substance was never found. The incident was called into the Ministry of Long-Term Care (MLTC) after hours reporting line on the day it was reported to the RN and a Critical Incident report was submitted by the home the following day.

Sources: Critical Incident report 610-000021-22 related to missing or unaccounted for controlled substances, home's medication incident and analysis form, Niagara Region Critical Incident and

mandatory Report Data Collection Form, Interview with RN and DRC. [740861]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which they were taken to hospital and that resulted in a significant change in their health condition.

Rationale and Summary

A Resident had a fall in 2022 for which they were taken to hospital and that resulted in a significant change in their health condition. No record of a critical incident report was found for this incident.

The Directors of Resident Care (DRC) confirmed that this resident had a fall in 2022 for which they were taken to hospital, and that the injury resulted in a significant change in the resident's health condition. They further indicated that the Director had not been informed of the incident.

Sources: Interview with SDM, triage notes for Ministry of LTC intake #19968, review of resident's progress notes and RAI MDS and interview with DRCs. [741074]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (a)

The licensee failed to ensure that as part of the home's medication management system, a controlled substance was destroyed by a team acting together and composed of i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii) a physician or a pharmacist.

Rationale and Summary

A critical incident report for a missing controlled substance was submitted to the Director in June 2022, related to a missing controlled substance incident in May 2022.

The home's policies indicated that this controlled substance was to be destroyed by a nurse and the pharmacist together, affixed to a LTC Secure Disposal Form, and when placed in the double-locked

location designated for controlled substances awaiting disposal this must be witnessed by another nurse.

On a specified date in May a RPN incorrectly disposed of a controlled substance by placing it in the garbage. Later in June they reported it to the RN. The RN and DRCs confirmed that the home failed to ensure that a controlled substance was destroyed by a team as per legislative requirements.

Sources: Interviews with DRCs and RN, the home's Medication Incident Report and Analysis Form, Care Rx policy 5.8 Medication Disposal - last revised March 2020, Care RX Policy 5.8.4 Medication Disposal – FentaNYL Patches – LTCH's-last revised October 2022 and Critical Incident Report 610-000021-22. [740861]

COMPLIANCE ORDER CO #001 Plan of Care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Licensee shall ensure that there is a process developed and implemented to ensure that bed alarms are in working order for all residents on the specified home area; and

2. Perform daily audits on all residents requiring bed alarms on the specified home area to ensure bed alarms are functioning and in working order for two weeks; and

3. Document the audits and actions made based on audit results; and

4. Keep a record of the audits for the LTCH inspector to review.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to multiple residents as specified in their plan.

A) Rationale and Summary

A resident had a specific intervention in their plan of care to mitigate falls. On a day in December 2022, the resident sustained an unwitnessed fall, which resulted in injury and hospitalization.

Staff stated that the specified intervention was not in place at the time of the fall. The resident was put at increased risk for injury as a result.

Sources: Internal investigation notes; resident care plan, task list documentation, progress notes; staff interviews; Critical Incident M610-000042-22. [740882]

B) Rationale and Summary

A resident who had difficulty swallowing was to receive a specified fluid consistency as per their plan of care to maintain adequate hydration while reducing choking episodes and inhalation of food and fluid particles, as medically possible.

On a specified day in May 2023 the resident was being fed a food item that does not meet the specified fluid consistency required at their lunch meal.

The Dietary Aide confirmed that per this resident's plan of care, they were not to have this food item. Another PSW overheard this conversation and admitted that they gave the food item to the resident by mistake. They immediately took the food item away from the PSW who was feeding the resident.

No negative impact to the resident was observed as a result of this non-compliance however, failure to follow the plan of care put the resident at risk for choking and inhalation of food particles.

Sources: Resident's care plan, meal observation of resident, interview with PSWs and Dietary Aide. [741074]

C) Rationale and Summary

A resident's plan of care at the time of inspection indicated the following goal related to their diagnosis of type two diabetes: maintain blood sugar levels within the resident's range.

The resident's blood sugar records indicated that their blood sugar was checked by the RPN on a date in March 2022 as per the Physician's orders and found to be above their range. Progress notes on this date show that nothing further was documented by nursing about this reading, and no action taken. The resident's blood sugar was not checked again for two weeks at which point it was found to be above the resident's range again, an almost identical reading to that of the one two weeks prior. At this point the resident was monitored more closely and the Physician was notified.

A RN indicated that the purpose of monitoring the resident's blood sugar was to determine whether or

not their blood sugar levels were in their normal range, and that it allowed staff to take action when needed. They indicated that looking at this resident's blood sugar reading in March 2022, it appeared to be higher than their specified range and that anything higher should have been communicated to the Physician.

For two weeks this resident was at risk for undetected, sustained and/or symptomatic hyperglycemia as a result of this non-compliance.

Sources: Resident's care plan, blood sugar records and progress notes, interview with RN. [741074]

D) Rationale and Summary

A resident's plan of care indicated that staff were to ensure their partial upper denture (PUD) was placed in their mouth during morning care. A PSW who was responsible for this task on a specified date in January 2023 admitted in an interview that when they went to insert the resident's PUD that morning it was not in the cup where it belongs. They indicated that they assumed it was already in the resident's mouth because sometimes staff could not remove it before bed and they slept with it in. The resident refused their oral care that morning and the PSW did not confirm with staff the location of the PUD.

Later in the day another a PSW was to perform the following task: Ensure PUD is in place at 3:00 pm. The PSW responsible for this task indicated that they had attempted to complete it but that the resident had resisted. This resident's plan of care indicated that if they were resistive to care staff were to leave and re-approach the resident in approximately 10 minutes. The DRC indicated that this intervention was applicable to all elements of care for this resident including oral care. The PSW confirmed that they were supposed to re-approach the resident when care was refused as per their plan of care however they did not re-approach the resident on this occasion to ensure their PUD was in place.

Around 8:00 pm the same day it was discovered that the PUD was missing and was found lodged in the resident's throat. Despite registered staff indicating that they inspected the resident's oral cavity earlier in the day, failure to ensure the resident's PUD was in place at morning care and again at 3:00pm may have inadvertently delayed the time in which it took staff to discover that the PUD was missing and was lodged in the resident's throat resulting in sustained pain and discomfort to the resident.

Sources: Resident's care plan, Documentation Survey Report January 2023, progress notes and interviews with PSWs and RPNs/RNs. [741074]

This order must be complied with by August 4, 2023