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: August 23, 2023

Inspection Number: 2023-1605-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: The Regional Municipality of Niagara

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

Lead Inspector	**Inspector Digital Signature**
Nishy Francis (740873)	Nishy Francis Digitally signed by Nishy Francis Date: 2023.08.29 09:07:49 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-11, and 14, 2023

The following Critical Incident intake(s) were inspected:

- Intake #00091901 (CI: M610-000025-23) related to resident care areas, and medication management.
- Intake #00090554 (complaint) related to medication management, food, nutrition, and hydration, and resident care and services.
- Intake #00090811 Follow-up compliance order related to plan of care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1605-0002 related to FLTCA, 2021, s. 6 (7) inspected by Nishy Francis (740873)

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

Continence Care
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

On an identified date, the physician ordered a medication for a resident and directed staff to inform the Substitute Decision Maker (SDM) prior to each medication administration.

On an identified date, on two separate occasions, the resident was provided medication without informing the SDM prior to administration.

When the home did not inform the SDM and administered the medication, the home failed to provide care to the resident as specified in the plan of care.

Sources: Interview with staff; review of resident clinical record, home's investigative notes.

[740873]