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

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Original Public Report

Report Issue Date: September 27, 2024.
Inspection Number: 2024-1605-0003
Inspection Type: Critical Incident
Licensee: The Regional Municipality of Niagara
Long Term Care Home and City: Northland Pointe, Port Colborne

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3 - 6, 9 and 10, 2024.

The following intake(s) were inspected:
- Intake: #00112011-Critical Incident (CI) #M610-000013-24 - related to prevention of abuse and neglect.
- Intake: #00112886-CI #M610-000014-24 - related to prevention of abuse and neglect.
- Intake: #00115397-CI #M610-000017-24 - related to prevention of abuse and neglect.
- Intake: #00119747-CI #M610-000024-24 - related to prevention of abuse and neglect.
- Intake: #00115536-CI #M610-000019-24 - related to infection prevention and control.
- Intake: #00120130-CI #M610-000025-24 - related to falls prevention and management.

The following falls prevention and management intakes were completed in this inspection:

- Intake: #00115809-CI #M610-000020-24.
- Intake: #00115818-CI #M610-000021-24.
- Intake: #00118582-CI #M610-000023-24.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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)
Plan of care
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.

The licensee has failed to ensure that the required number of staff and level of assistance were provided to a resident during their care.

Rationale and Summary
A) A resident required extensive two-person assistance with certain activities of daily living and total assistance with two staff for other activities of daily living. The resident alleged they received an alteration to their skin integrity by staff on an

identified date.

According to the home's internal investigation notes and interviews, two staff member's acknowledged that on the same date, they provided care to the resident without the assistance of another staff.

The resident was placed at risk of harm when staff provided one person assistance instead of two person extensive/total assistance when care was provided to them.

Sources: A CI report; home's internal investigation notes; a resident's clinical record; interviews with PSW's and other staff.

B) The licensee has failed to ensure that a resident's device was applied as specified in their plan of care.

Rationale and Summary
An alteration to a resident's skin integrity was identified on a specified date. The resident had a known health condition that when present, required the use of a device, as per their plan of care.

The home's investigative notes and interviews confirmed that a staff member had provided morning care to the resident and observed the resident to be demonstrating the health condition. The staff member indicated they had not noticed the device in the resident's room, to apply.

Interviews with staff confirmed that care had not been provided to the resident as per their plan of care.

When the resident was not provided care as per their plan of care, this had the

potential to contribute to the harm the residents sustained to their health and well-being.

Sources: A CI report; the home's investigative notes; resident's care plan, kardex, Point of Care (POC) tasks, progress notes and interviews with the Directors of Resident Care (DRC's).

WRITTEN NOTIFICATION: Reassessment, revision

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee failed to ensure that different approaches were considered in the revision of a resident's plan of care.

Rationale and Summary
A resident had a known history of demonstrating a responsive behaviour toward staff. Staff utilized approaches to manage this behaviour. On an identified date, the resident had an altercation with a co-resident and staff implemented additional interventions.

The resident continued to exhibited physical aggression towards co-residents and also towards staff. Interventions in place were implemented. The resident then had instances of the responsive behaviour towards co-residents with one sustaining an

injury. A new intervention was implemented and the resident's responsive behaviour improved.

When the resident continued to demonstrate the responsive behaviour towards co-residents over a period of time, the interventions put into place at the onset were not effective at preventing the resident from continuing to pose a risk of harm to other residents. The plan of care was reviewed and revised during this time; however, different approaches were not considered, where they were available, to manage the behaviour.

Failure to ensure that different approaches were considered in the revision of the resident's plan of care during the time frames above, increased the risk of harm to residents that resided on the same home area.

Sources: A resident's plan of care and interviews with a Registered Nurse (RN) and the DRC.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A) The licensee failed to protect a resident from physical abuse by another resident.

Ontario Regulation 246/22 section 2 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais

traitements d'ordre physique")".

Rationale and Summary
A resident grabbed a co-resident's arm and pulled them down resulting in an alteration to their skin integrity.

Failure to protect the resident from physical abuse by another resident resulted in actual harm.

Sources: A resident's progress notes, risk management, a second resident's assessments, and interviews with Personal Support Worker (PSW), Registered Practical Nurse (RPN) and the DRC.
B) The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Ontario Regulation 246/22 section 2 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")".

Rationale and Summary
A resident was to have a 1:1 staff person for their care. On an identified date, the staff left the resident unattended and upon their return found this resident in an altercation with another resident resulting in an injury.

Failure to protect the resident from physical abuse by another resident resulted in actual harm.

Sources: A resident's progress notes, the second resident's assessments, and an interview with the DRC.

C) The licensee has failed to ensure that a resident was protected by neglect.

Legislation 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.

A resident was identified with an alteration to their skin integrity. They had a history of a known health condition.

Rationale and Summary
a) The home's investigative notes and interviews indicated that on a specified date, staff were unable to locate a device used by the resident and attempted to apply another intervention without success as the resident verbalized pain and refused care. Registered staff attempted to apply the intervention and were also unsuccessful. Registered staff indicated they had not observed any skin concerns. No further interventions or actions were taken.

Investigative notes, interviews and review of clinical records confirmed registered staff had not completed a documented pain assessment, implemented strategies to manage their pain and document these events in the resident's clinical record.
b) The home's investigative notes and interviews indicated on a specified date, registered staff had been asked to assess the resident's known health condition. The staff indicated no open area was present and they observed discomfort to the resident's face and stopped the assessment. They advised staff to perform an intervention; however, the staff indicated this intervention was ineffective when tried before. It was confirmed registered staff had not completed a documented pain assessment, implemented strategies to manage the resident's pain and

documented these events in the resident's clinical record.

When actions were not taken to provide the resident with treatment and care on the above dates, this contributed to the actual harm the resident sustained to their health and well-being.

Sources: A CIS report; the home's investigative notes; a resident's clinical records and interviews with registered staff, DRC's and others.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, were documented.

A resident was identified with an alteration to their skin integrity. They had a history of a known health condition.

Rationale and Summary
Review of the home's investigative notes; documentation and interviews conducted, indicated on several identified dates, staff were unable to provide specified care to the resident as the resident had either refused and/or demonstrated pain. It was confirmed no documentation was entered into the resident's clinical record when

care was unable to be completed on these dates.

No documentation for the above events had the potential to contribute to the actual harm the resident sustained by potentially impacting the ability to monitor for trends, determine cause and take action in a timely manner.

Sources: The home's investigative notes; a resident's clinical records and interviews with the DRC's and other staff.

WRITTEN NOTIFICATION: Foot care and nail care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee has failed to ensure that a resident received fingernail care, including the cutting of their fingernails.

Rationale and Summary

A resident was identified with an alteration to their skin integrity. They had a history of a known health condition.

The home's policy Nursing and Personal Support Services indicated every resident would receive fingernail care, including the cutting of fingernails.

Review of the home's investigative notes; documentation and interviews, indicated on three specified dates, the resident had not had their fingernails or not all of their

fingernails trimmed.

When the resident demonstrated a health condition and their fingernails were not routinely cut this resulted in an alteration to their skin integrity.

Sources: A CIS report; the home's investigative notes; a resident's plan of care and interviews with the DRC's and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that for a resident who was demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Rationale and Summary
A resident had a known history of physical aggression towards staff. On a specified date, documentation indicated the resident demonstrated physical behaviours for the first time towards other co-residents. No harm occurred and staff intervened. Documentation indicated staff would continue to monitor the resident for behaviours.

The DRC indicated when a new behaviour is demonstrated, a specified assessment

should be initiated to determine the cause of the behaviour. The assessment was not initiated following this incident, and no further changes to the plan of care were made at this time. Another day, the resident initiated another physical altercation with another resident and the other resident sustained an injury.

Failure to ensure that the assessment was initiated may have increased the risk of harm to fellow residents on the same home area.

Sources: A resident's plan of care and interviews with Registered staff and a DRC.