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

Public Report

Report Issue Date: April 2, 2025
Inspection Number: 2025-1605-0001
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): March 21, 24-28, 31, 2025 and April 1-2, 2025

The following intake(s) were inspected:

- Intake: #00125666-M610-000032-24 - Fall Prevention and Management
- Intake: #00125962-M610-000033-24 - Resident Care and Services.
- Intake: #00126018 -M610-000034-24 - Prevention of Abuse and Neglect.
- Intake: #00130001 -M610-000044-24 - Resident Care and Services.
- Intake: #00130235-M610-000045-24 - Prevention of Abuse and Neglect/Responsive Behaviours.
- Intake: #00134893 -M610-000048-24 - Medication Management.

The following intake(s) were completed:

- Intake: #00132181-M610-000047-24 - Fall Prevention and Management.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 failed to ensure that a resident's fall prevention intervention was provided, as specified in their plan.

The resident sustained a fall resulting in an injury. Their falls plan of care indicated staff were to ensure the fall prevention intervention was in place. It was determined that this intervention was not provided by staff as expected.

When the resident's fall prevention intervention was not provided, this had the potential risk of contributing to the injury that occurred.

Sources: CIS #M610-000032-24, resident's progress notes, care plan, post-fall assessment, and an interview with the Administrator.

COMPLIANCE ORDER CO #001 Residents' drug regimes

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 146 (b)

Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(b) appropriate actions are taken in response to any medication incident involving a resident, any incidents of severe hypoglycemia and unresponsive hypoglycemia and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Educate a specified staff on the home's hypoglycemic treatment policy and procedures, which will include but is not limited to, responsibilities of the staff when a resident has severe or unresponsive hypoglycemia, when and how to complete a medication incident report, as well as when the physician and director of care should be contacted; and
b) Maintain written records of the education provided and the name of staff who received and completed education; and
c) Conduct audits once per week on the specified resident's hypoglycemic management to ensure that, in the event of any identified hypoglycemic incident, that staff followed the home's hypoglycemic treatment policy and procedures. Conduct these audits for a period of one month, totaling at minimum four audits; and
d) Maintain records of all audits conducted, including the dates and times they were done, who conducted them, the results of each audit, and if any follow-up training or interventions were required, and if so, include what the training or intervention entailed.

Grounds
The appropriate actions for a resident with severe hypoglycemia who remains conscious, have been defined by the LTCH under their policy titled Hypoglycemic Treatment, dated December 13, 2024.

A resident experienced severe hypoglycemic blood sugar readings for two consecutive days. For all three instances, the physician and Director of Resident Care (DRC) were not informed through the appropriate action of submitting a medication incident report (MIR) in a timely manner, as per the LTCH's expectations and policy.

For the third instance of severe hypoglycemia, the staff did not apply other identified appropriate interventions as per the home’s policy. During re-assessment by staff, the resident continued to have fluctuating level of consciousness and required hospitalization.

Post-hospitalization and upon the resident’s return to the LTCH, the MIR’s were completed for physician’s review for the previous three incidents, and other appropriate parties were informed. The physician stated that they should have been informed about the incidents sooner.

Staff failed to ensure appropriate actions were taken for the resident's several severe hypoglycemic incidents when the physician was not made aware of the pattern of concerns. Consequently, the physician was unable to reassess the resident in a timely manner, which could have prevented the negative outcomes.

Sources: Resident's clinical record including progress notes, MIRs, assessments, and electronic medication administration record; Interviews with staff and DRC; the home's internal investigation notes; the home's policy titled Hypoglycemic Treatment.

This order must be complied with by May 2, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.