Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, Apr 3, 26, May 8, 9, 2012	2012_064167_0006	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, 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

MARILYN TONE (167), ELISA WILSON (171), GILLIAN HUNTER (130), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Office Manager, registered Staff and personal support worker staff on the units, the Registered Dietitian, the Recreation Manager, the Manager of Dietary and Housekeeping Services, dietary aides, the Cook, the Resident Assessment Instrument Coordinator, residents and family members. This Resident Quality inspection has been logged as H-000475-12.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, storage areas, and care provided to residents, reviewed resident records and plans of care for identified residents, reviewed policies and procedures at the home and observed the general maintenance, cleaning and condition of the home.

An Environmental Inspection was completed simultaneously with this inspection. Refer to Inspection Log # H-000598-12

The following Inspection Protocols were used during this inspection:

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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.) 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. 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has not ensured that the written plan of care gives clear direction to staff who provide direct care to residents [LTCHA, 2007 S.O. 2007, c.8, s.6(1)(c)]

An identified resident was observed with a front fastening seat belt applied while in their wheelchair as a Personal Assistance Service Device (PASD) and had two quarter bed rails applied while in bed. This information was included on the most current computerized plan of care however the printed version of the care plan and Kardex had not been reprinted after this information was added in March 2012. The printed Kardex primarily used by the Personal Support Workers was dated January 11, 2012 and indicated under the category, Safety, that a side mount seat belt was to be used when in the wheelchair and one side rail up while in bed. Staff confirmed the Kardex information was outdated and a new copy was printed during this inspection.

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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, protocol, procedure, strategy or system instituted or otherwise put in place at the home was complied with related to the use of a Personal Assistance Service Devices (PASD) for an identified resident. [O.Reg. 79/10, s. 8(1)b]

- During an observation of the identified resident while they were in bed, it was noted that there were two three quarter bed rails elevated on their bed.
- During an interview with registered staff on the resident's unit, it was noted that the resident currently does not attempt to exit the bed and that the bed rails are in place to prevent the resident from falling out of bed. The plan of care also indicated that the resident requires positioning every two hours related to skin breakdown.
- The home's policy related to PASD that was provided on the home's on line intranet (Sherpa) and confirmed to be the home's current policies by the Administrator, Director of Care and Office Manager indicates that two bed rails, if the resident requires them to prevent falling out of bed are considered to be a PASD. It was noted that the staff at the home did not follow the home's policy related to PASD with regards to the following:
a) A review of the resident's health file revealed that there was no documented approval by a physician, registered nurse, registered practical nurse, occupational therapist or physiotherapist for the use of the PASD for the resident.
b) There was no documentation to indicate that consent was obtained from the resident or their substitute decision maker for the use of a PASD.
c) It was noted that the resident's plan of care did not indicate the reason for use of the PASD or what alternatives were tried and why they were not suitable.
d) The plan of care for the resident did not indicate the focused goal to support Activities of Daily Living (ADL) for which the device was required or interventions which include frequency of monitoring.
e)The plan of care did not include quarterly monitoring/ detailed Resident Assessment Protocol (RAP) as per the home's policy.
f) The plan of care did not include documented monitoring using the PASD Flow sheet as indicated in the policy.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has not ensured that any actions taken with respect to a resident under a program, including interventions and responses to interventions were documented.[O.Reg.79/10, s.30(2)]

An identified resident was using a seatbelt as a Personal Assistance Service Device (PASD) while in their wheelchair. An intervention was included in their plan of care to complete the PASD flow sheet hourly to document that the resident has been checked for proper positioning and every two hours to document that the resident has been repositioned. The flow sheet for February 2012 was missing some documentation. There were no entries for the day shift on February 11,14,and 26, 2012. There were no entries for the afternoon shift on February 1,5,11,12,15,19,22,23,25, 2012. Personal support worker staff and registered staff confirm that the resident's usual routine is to be up in their wheelchair for breakfast until the afternoon. The resident rests in bed in the afternoon and gets up in their wheelchair for dinner. Personal support workers, registered staff and the Director of Care confirmed the expectation was to complete the PASD flow sheet on both the day and afternoon shifts each day.
2. a) A second identified resident had an indwelling catheter with an intervention in their plan of care to record urinary output each shift. A Catheter Output record was included in the residents health record in order to record urine output per shift with comments and staff initials. The record for February 2012 was missing output information for 38 out of 87 shifts.
b) A third identified resident had an indwelling catheter with an intervention in their plan of care to record urinary output each shift. A Catheter Output record was included in the residents health record in order to record urine output per shift with comments and staff initials. The record for February 2012 was missing output information for 49 out of 87 shifts. Registered staff indicate that sometimes output was recorded on a calendar which was not a part of the health record and sometimes in the progress notes. Registered staff and the Director of Care confirmed the expectation was to have the output recorded on the Catheter Output sheet for all shifts each day.
3. a) The food/fluid records for an identified resident were missing information regarding nutritional intake for 13 meals and snacks in January 2012 and 7 meals and snacks in February 2012. This resident was assessed as having a critical risk for dehydration and a note to encourage fluids was stamped on the food/fluid record.
b) The food/fluid records for another identified resident were missing information regarding nutritional intake for 10 meals and snacks in January 2012 and 3 meals and snacks in February 2012. This resident was assessed in December 2011 as being at high nutritional risk due to being underweight and having a poor nutritional intake.
- Personal support workers and registered staff confirmed the information was not documented and that the expectation was that intake for each meal and snack should be documented, including coding for instances when the resident refuses or is not available to take the meal or snack.

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 any action taken with respect to a resident under a program, including interventions and resident's responses to interventions are documented., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident was offered a dental assessment and other preventive dental services, subject to payment being authorized by the resident/substitute decision maker.[O.Reg.79/10s.34(1)C]

- The identified resident was observed to have a number of broken teeth and caries in their mouth.
- It was noted in the progress notes on the resident's health file that the resident had an identified behaviour and was to be monitored for pain.
- An interview with the Registered Practical Nurse on the unit confirmed that the resident has not had a dental assessment since their admission to the home.
- It was confirmed that there was a signed consent by the resident's substitute decision maker on their health file that included consent for an annual oral exam by the dentist. This consent was dated when the resident was admitted.
- Registered staff confirmed that the resident's substitute decision maker would be notified and a dental assessment initiated on the day of the interview.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee had not ensured that for every verbal complaint made the corresponding documentation was completed [O.Reg. 79/10, s.101(2)(c)(d)(e)].

The home has a food committee with minutes documenting complaints and suggestions from the residents regarding food and food service, however, action plans, follow-ups and resolution of the concerns were not documented for all complaints. For example, the December 2011 minutes indicated residents would like to see poached eggs on the menu for breakfast once per week, and there was a concern that the food was cold at supper time. The minutes of the following meeting in February 2012 did not address the resolution of these items and included a repeated concern regarding supper meals being cold.

A documented record was not produced indicating; the type of action taken to resolve the concerns, including the date of the action, time frames for actions to be taken and any follow-up required; the final resolution; every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 r. 8.	CO #001	2011_063165_0002	171
O.Reg 79/10 r. 26.	CO #002	2011_063165_0002	171

Issued on this 29th day of May, 2012

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

Marilyn Lowe