Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2021	2021_569508_0007	016786-20, 020837-20	Complaint

Licensee/Titulaire de permis

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

Long-Term Care Home/Foyer de soins de longue durée

Niagara Long Term Care Residence
120 Wellington Street P.O. Box 985 Niagara On The Lake ON L0S 1J0

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 15 - May 6, 2021.

The following complaints were inspected:
- Log #016786-20, related to resident care concerns including skin and wound, falls prevention and management, pain management and responding to complaints;
- Log #020837-20, related to improper medication administration, continence care, falls prevention and management.

Critical Incident inspection #2021_569508_0008 was conducted concurrently during this Complaint inspection.

During the course of the inspection, the inspector toured the facility, observed residents, the provision of care, reviewed resident clinical records, relevant policies and procedures and conducted an Infection Prevention and Control Assessment.

During the course of the inspection, the inspector(s) spoke with the Administrators, the Director of Care (DOC), the Assistant Director of Care (ADOC), registered staff, Personal Support Workers (PSW), resident and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Pain
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(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. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the plan of care related to falls management was revised because care set out in the plan had not been effective, different approaches were considered in the revision to the plan of care for residents #002 and #003.

a) A complaint was submitted to the Director related to care concerns of a resident including falls management.

The resident was admitted to the home in 2020 with no history of falls. The resident fell attempting to self transfer and rolled out of bed while attempting to reposition themselves. Two days later, a post admission care conference was conducted. Documentation indicated that the resident's fall interventions were effective at keeping resident safe; however, the resident had fallen twice since admission.

The Resident Assessment Protocol (RAP) indicated that at the time of the assessment, the resident had fallen five times since admission to the home. Post fall assessments indicated that the resident had an additional two falls after that assessment was conducted.

It was confirmed that when the falls plan of care was revised, not all interventions or different approaches were considered.

Sources: post fall assessments, resident plan of care, progress notes and interview with staff #102. [s. 6. (11) (b)]

2. b) Resident #002 had cognitive impairment and was at high risk for falls. The resident had two falls in 2021 that resulted in injuries in addition to several other falls without

injury.

The post fall assessments identified a pattern of the resident attempting to ambulate or transfer without assistance.

The resident's plan of care indicated that falls interventions had been revised, but not until after the resident's second fall with injury. By not considering different approaches in the revision of the plan of care, the resident remained at risk for falls.

Sources: CI #2618-000002-21, CI #2618-000004-21, post fall assessments, resident plan of care, and interview with staff #102. [s. 6. (11) (b)]

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 when the plan of care is being revised because care set out in the plan had not been effective, different approaches are considered in the resident's plan of care, to be implemented voluntarily.

Issued on this 31st day of May, 2021

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

Original report signed by the inspector.