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

Division de la responsabilisation et de la performance du système de santé
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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
May 11, Jun 6, 2012	2012_074171_0004	Complaint

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

DOUGLAS H. RAPELJE LODGE
277 PLYMOUTH ROAD, WELLAND, ON, L3B-6E3

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

ELISA WILSON (171)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the administrator, registered staff, health care aides and residents.

During the course of the inspection, the inspector(s) the inspector toured the home, had workers demonstrate the chair alarm system and call response system, reviewed the plans of care of identified residents and reviewed specific home policies.

H-002360-11
H-002371-11

This report is equivalent to Inspection # 2012_067171_0011 which was completed April 17-20, 2012 in a Word document and provided to the home on May 8, 2012.

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee had not ensured that the resident-staff communication and response system was easily seen and accessed by residents at all times.

A resident was observed sitting in a wheelchair in the bedroom near the end of the bed. The wheelchair foot rest was caught on the bedside table and the resident was unable to move the chair or the table. The call bell was on the floor next to the head of the bed and out of reach. The call bell was tested and did not activate when pressed. Staff indicated the resident had another call bell the resident usually had nearby however it was not with the resident at that time. A health care aide confirmed the call bell attached to the wall was not in working order and the other call bell was not with the resident.

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 the resident-staff communication and response system is easily seen and accessed by residents at all times, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee had not ensured that the Falls Prevention Program had a written description of the program including goals and objectives, relevant policies, procedures and protocols, methods to reduce risk, methods to monitor outcomes and protocols for referral of resident to specialized resources.

The administrator confirmed the home had a draft falls prevention program started however it had not been implemented in the home at the time of this inspection.

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 the home has a written description of the Falls Prevention Program, to be implemented voluntarily.

WN #3: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had not ensured the written plan of care set out clear direction to staff who provide care to the resident. [LTCHA, 2007 S.O. 2007, c.8, s.6(1)(c)]

A resident's plan of care, in the Risk of Falls section, indicated specific call bell procedures and equipment to be used, however the information was vague. Different staff members understood the instructions in different ways. It was unclear in the written plan of care if and when the resident should have this particular call bell system in place.

2. The licensee had not ensured the plan of care was reviewed and revised when the resident's care needs changed. [LTCHA, 2007 S.O. 2007, c.8, s.6(10)(b)]

The physician discontinued the use of a specific restraint as per the physician's written orders for an identified resident. This change was also documented in the progress notes. The mobility care plans completed since that time still indicated a restraint was in use. The administrator confirmed this restraint was not being used after it was discontinued by the physician and that the plan of care was not updated when the change was made.

Issued on this 6th day of June, 2012

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