Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2017	2017_577611_0002	000123-17	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

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

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

KELLY CHUCKRY (611), KERRY ABBOTT (631), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 9, 10, 11, 12, 16, 17, 18, and 19, 2017.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, reviewed applicable clinical health records, policies, procedures, practices, and investigation notes. Two complaint inspections were conducted concurrently with this Resident Quality Inspection.

The two complaint inspections included Log # 036191-15 related to the prevention of abuse and neglect and Log # 027123-16 related to the prevention of abuse and neglect, staffing, reporting of complaints, and plan of care.

During the course of the inspection, the inspector(s) spoke with residents, family members, a complainant, the Administrator, Director of Resident Care (DRC), Clinical Documentation and Infomatics Coordinator (CDI Coordinator), Manager of Resident and Community Programs (MRCP), maintenance coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_341583_0021	631

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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A review of resident #018's clinical record indicated that the resident exhibited numerous issues related to altered skin integrity. According to the written plan of care, the resident required the use of a mechanical sling lift for transfers. The resident also required specific interventions for the altered skin integrity.

On two identified dates in January 2017, the resident was observed to have an intervention in place.

An interview with staff #109 indicated that staff routinely implement this intervention. An interview with the DRC further confirmed that this intervention was routinely implemented for this resident.

An interview with the ADRC confirmed that this was not in the written plan of care. [s.6. (1)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #029 had a history of responsive behaviours. On an identified date, the physician discontinued the use of a medication for resident #029 and initiated the use of another medication. The Substitute Decision Maker (SDM) for resident #029 was given the opportunity to participate fully in the development and implementation of the plan of care for this resident.

On a subsequent identified date, the home received a phone order from the physician for the use of the original medication that had been previously discontinued.

A review of the clinical health record for resident #029 revealed that the home did not contact the resident's substitute decision maker (SDM) to discuss the reordering of this medication.

The re-ordered medication was administered to resident #029 eleven times during the month of December 2015, at which time the SDM requested that the medication be discontinued.

An interview conducted with the Administrator and DRC confirmed that the home did not provide the resident's SDM with the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, to ensure that the plan of care set out clear direction to staff and others who provide care to the resident, and to ensure that the resident, the resident's substitute decision maker, if any, and any other persons designated by the resident or substitute decision maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensured that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access were kept closed and locked.

On January 9, 2017, during the initial tour of the home, the Inspector observed an exit door leading to the outside rear of the building to be unlocked. The door had signage posted which stated that the door was to be locked at all times. The Inspector observed a keypad locking mechanism which appeared to be disabled, rendering the door to be unsecured.

An interview with the DRC confirmed that the door was to be locked at all times and that the keypad had been disabled and the door unsecured to the outside. [s. 9. (1)]

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 all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies, terraces, or doors that residents do not have access to are kept closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the care plan was based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement coordinator under section 44 of the Act.

A review of Resident #001's clinical record indicated that the resident was admitted to the home on an identified date. On a subsequent identified date, an incident occurred which resulted in minor injuries. The resident's Hospital Minimum Data Set Assessment, completed by the placement coordinator, prior to admission, under section K, indicated that the resident had previously suffered two (2) falls.

A further review of the resident's clinical record indicated that in the home's Admission Minimum Data Set (MDS), under section V, the Resident Assessment Protocol (RAP) section, the resident was identified to have sustained a fall one (1) time in the last thirty-one to one hundred and eighty (31-180) days.

An interview with registered staff #101 confirmed that the coding was documented purposefully as one (1) fall in the last thirty-one to one hundred and eighty (31-180) days, despite the fact that two (2) falls were documented in the Hospital MDS assessment. The staff stated that they had disregarded the Hospital MDS documentation and had relied on other documents received in transport from the hospital to base their assessment of the resident's risk for falls.

An interview with the DRC indicated that the admission assessment by the home was to be set out based on assessments provided by the placement coordinator; specifically the MDS assessment. [s. 24. (4)]

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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and on the assessment, reassessments and information provided by the placement coordinator under section 44 of the Act, to be implemented voluntarily.

WN #4: 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:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 48 (1) that required a long term care home to ensure that there was an falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review or resident #022's plan of care indicated that the resident was admitted to the home on an identified date. At the time of admission, the home had completed a Henrich Fall Risk Assessment, which identified this resident as a risk for falls. According to the resident's clinical health record, the resident had ten (1)) fall incidents during an eight (8) month period of time in 2016. A review of the resident's Minimum Data Set, Resident Assessment Instrument (MDS-RAI) coding on an identified date during this time frame, indicated that the resident had underwent a significant change of status.

A review of the home's Falls Prevention policy, dated April 5, 2011 and revised May 11, 2016, under the heading, "Fall Risk Assessment for Residents", stated, "Residents will be assessed for their fall risk using Hendrich Fall Risk assessment upon admission to the home, upon re-admission where the resident has required a "Re-Admission Assessment" and with a significant change in status. A further review of the resident's record indicated that Hendrich Fall Risk Assessment was not completed after the resident was identified to have exhibited a significant change in status related to a significant decline in some areas of their ADLs.

An interview with the Director of Resident Care confirmed that according to the home's Falls Prevention Program policy, a Henrich Falls Risk Assessment should have been completed and was not completed for the resident at the time of a significant change in status. [s. 8. (1)]

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.