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
Apr 20, 2017	2017_542511_0002	035049-15, 035325-15, 016414-16, 023400-16, 032036-16, 002161-17, 002677-17	Critical Incident System

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

ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 26, 27, 30, 31, 2017 and February 1, 2, 7, 8, 9, 2017.

The following intakes were inspected: 002161-17 (medication administration), 000935-17 (Inquiry on Outbreak reporting), 032036-16 (alleged staff to resident abuse), 023400-16 (resident to resident abuse, responsive behaviours), 016414-16 (resident to resident, responsive behaviours) 0350049-15 (fall with injury) and 035325-15 (alleged sexual abuse).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Clinical documentation and information lead, Personal Support Workers (PSWs) and residents.

The Inspector observed the provision of resident care, reviewed clinical records and reviewed applicable home policies and practices.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that resident #008 was protected from abuse by anyone.

On a specified date in 2015, the licensee submitted a mandatory report to the Ministry of Health and Long Term Care (MOHLTC) for resident to resident abuse from resident#007 to resident #008.

A review of the clinical record identified resident #008 required extensive assistance, from staff for all care, which included transferring and bed mobility. Resident #008 was identified, in their Minimum Data Set (MDS) quarterly assessment, to be cognitively impaired and required medication that had a sedative effect.

A review of the clinical record identified resident #007 did not require any assistance for ambulation. Resident #007 had mild cognitive impairment and had been observed on two separate occasions, prior to the abuse, to have inappropriate contact with and inappropriate observation of resident #008.

On an identified date in 2015, PSW #022 reported that they witnessed an incident where resident #007 had unsupervised physical contact with resident #008. PSW #022 stated that they were surprised to see resident #007 with resident #008 and had alerted PSW #029 to the incident.

PSW #020 stated they observed resident #008 looking scared and appeared agitated after the incident. PSW #022 stated they had provided care on several occasions to resident #008 and stated the resident had a change in their behaviour immediately after the contact with resident #007.

Interview with RPN #024, who was identified as working on the identified date in 2015, confirmed they were notified by the two PSWs of the incident and had immediately notified the RN in charge. RPN #024 stated resident #008 was cognitively impaired and could not consent or had the capacity to consent to resident #007's physical contact.

RN #019 was identified as being the nurse in charge on the identified date in 2015. RN #019 confirmed they were in charge of the building and had been notified of the incident as described above. RN #019 stated they completed an assessment of resident #008 and put interventions in place for resident #007, to protect resident #008, from any further contact by resident #007. RN #019 confirmed the family, police and MOHLTC had been immediately notified. On an identified date, the Resident Social Worker (RSW) documented they had followed up with resident #008 to ensure their well-being following the 2015 incident. No further concerns were documented for resident #008.

Interview with the DOC and the Administrator confirmed resident #008 was not able, and had not consented to the physical contact from resident #007 on the identified date and that the licensee had failed to ensure the resident was protected from abuse, by anyone. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of the clinical record indicated the resident #003 was admitted to the Long Term

Care home (LTCH) with cognitive impairment and responsive behaviours. The resident had been followed by the Behaviour Supports Ontario (BSO) and had assisted the resident with their transition to the LTCH.

A) BSO saw the resident on several dates in 2016 and had identified the resident behaviours. Dementia Observation System (DOS) charting, for the identified dates in 2016, was completed by the home and had described the resident's responsive behaviours. A review of the resident's plan of care identified the triggers for their responsive behaviours and identified specific interventions. On an identified date in 2016, documentation indicated the resident had a triggered behaviour, from another resident, and the intervention the staff implemented was successful in reducing an altercation.

Observation of resident #003, on three separate dates in 2017, had not identified the interventions had been in place. Interview with PSW #016 stated the intervention had not been implemented in the previous three months and PSW #011 indicated the intervention was no longer effective. Both staff stated they had not known if the intervention was effective in preventing the known trigger of the resident's responsive behaviour. Interview with Registered staff #015 and #013, indicated they were unsure if the intervention was still effective in reducing responsive behaviours as the resident's had a change in their condition. A review of the clinical record and the Responsive Behaviour Team meeting minutes, for a month identified in 2016, had not identified documentation of a reassessment or the resident's ongoing response to the intervention since the resident's change in their condition.

B) BSO notes and a review of the clinical record identified resident #003 had demonstrated behaviours on a specific date in 2016 that required staffing interventions, for an undefined period of time, to promote the resident's safety. There was no documentation of a resident reassessment or their response to the staffing intervention until a Social Worker (SW) documented the resident was assessed nearly 12 days later. Approximately one month later, there was no documentation to indicate responses to the staffing intervention or if the intervention was still required or in place. A progress note indicated a responsive behaviour occurred between resident #003 and resident #002 on a later identified date in 2016. The home submitted a CIS #M604-000006-16 for a resident to resident altercation and stated #002 sustained an injury from #003 related to the altercation. A review of the High Intensity Needs Funding (HINF) form identified the home had initiated an intervention for resident #003, for the identified dates and had discontinued the intervention with no resident documentation, reassessment or responses for the reason for discontinuing the intervention.

Interview with the Administrator confirmed the licensee had failed to ensure that for resident #003, who had demonstrated responsive behaviours for a period of greater than two months, that actions were taken to respond to the needs of the resident which included assessments, reassessments, staffing interventions and that the responses to interventions were documented.

C) A review of the clinical record indicated resident #009 was admitted to the Long Term Care home (LTCH) with cognitive impairment and responsive behaviours. The resident had been followed by the BSO and had assisted the resident with their transition from the hospital to the LTCH.

Progress notes for an identified date in 2016, indicated the resident demonstrated a responsive behaviour that placed them at a safety risk. An RN witnessed the responsive behaviour and required the assistance of staff to ensure the resident's safety. The resident was provided with behavioral interventions for a period of approximately one month following the incident.

There were no progress notes indicating an assessment, reassessment or resident's responses to interventions were documented for 12 of the 34 days where the interventions were in place.Interview with the DRC indicated the DOS charting was to be completed for 24 hours period on the days the resident remained at risk for responsive behaviours and that there was no documentation available for the other shifts.

A review of the Behaviour Assessment record (BAR) that the home used to monitor the resident response to the intervention was not documented for five identified days in 2016.

On an identified date in 2016, the behavioural intervention was removed and then reimplemented for two consecutive days 2016 . A review of the clinical record, including the DOS, BAR and progress notes, for the days identified above, had not provided any documentation related to the responses to the behavioural interventions as required by r. 53. (4) (c) and the home's Responsive Behaviours Program, index # RKM00-015.

Interview with the Administrator confirmed there were inconsistent assessments, reassessments and interventions for resident #009's responsive behaviour and that the resident's responses to interventions were not consistently documented. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours, (c) actions will be taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, 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:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the clinical record identified resident #001's plan of care described the resident had moderate cognitive impairment and required assistance with their activities of daily living. The plan of care directed staff to break down the activities into sub tasks and to give one instruction at a time. Staff were directed to be careful when providing personal care as the resident experienced weakness and limited range of motion.

According to the clinical record, on an identified date in 2016, the resident sustained an injury when they were assisted with personal care from PSW #010. The resident had complained that they felt the staff had rushed when they were provided care and felt discomfort with the care provided. Resident #001 was assessed by the registered staff and documented to have an injury. The resident was provided medication and was reassessed by the treating physician and an injury was confirmed.

Observation of resident #001 revealed a well groomed, pleasant and cooperative resident who was able to identify their caregivers on an identified date. The resident stated that they experienced discomfort when staff rushed their care. Interview with PSW #010 stated they provided care to the resident on the date of the injury and had not known the specific care needs of the resident, as identified in the plan of care.

Interview with the Administrator confirmed the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when they sustained an injury during the provision of personal care by PSW #010. [s. 6. (7)]

Issued on this 9th day of May, 2017

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

Original report signed by the inspector.