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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 15, 22, 2018	2018_575214_0001	029205-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of Niagara
2201 St. David's Road P.O. Box 344 THOROLD ON L2V 3Z3

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

CATHY FEDIASH (214), KELLY CHUCKRY (611), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 9, 10, 11, 12, 15, 16, 17, 2018.

The following inspections were conducted simultaneously with the Resident Quality Inspection:

Critical Incident System Inspections:
005527-17- related to: Falls Prevention and Management
006292-17- related to: Prevention of Abuse and Neglect

011287-17- related to: Falls Prevention and Management
019094-17- related to: Prevention of Abuse and Neglect
021311-17- related to: Falls Prevention and Management

Inquiries:
020448-17- related to: Falls Prevention and Management
024740-17- related to: Prevention of Abuse and Neglect; Medications; Personal Support Services
025638-17- related to: Prevention of Abuse and Neglect
016933-17- related to: Prevention of Abuse and Neglect
011026-17- related to: Falls Management and Prevention
018867-17- related to: Sufficient Staffing
006299-17- related to: Prevention of Abuse and Neglect
029593-17- related to: Medications; Responsive Behaviours
009805-17- related to: Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Associate Director of Resident Care (ADRC); Environmental Services Manager; Programs Manager; Clinical Documentation and Information Coordinator (CDI Coordinator); Registered Nurses (RNs); Registered Practical Nurses (RPNs); Personal Support Workers (PSWs); residents and families.

During the course of the inspection, the inspector(s) reviewed Critical Incident System (CIS) reports; resident clinical records; reviewed policies and procedures; reviewed medication incidents; reviewed meeting minutes; reviewed investigation notes; conducted a tour of the home; observed residents during the provision of care and observed medication administration.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **2 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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Medication incidents were reviewed for an identified period of time.

An identified number of medication incidents had not been reported to the resident, or the resident's SDM, and an identified number of medication incidents had not been reported to the physician. In an interview conducted with the Administrator and DRC, it was acknowledged that the home did not consistently report medication incidents to the resident, resident's SDM, or physician. [s. 135. (1)]

2. The licensee failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b).

Medication incidents were reviewed for an identified period of time. In addition, the minutes from the home's Professional Advisory Meetings (PAC), as well as the minutes from the Medication Safety Meetings were reviewed for an identified time period.

An interview was conducted with the Administrator and the DRC, and it was acknowledged that the home had not ensured that quarterly reviews were undertaken of all medication incidents that included the implementation of any changes and improvements identified in the review. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long-Term Care Homes Act, 2007,

"emotional abuse" means, subject to subsection (2),

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviours or remarks understands and appreciates their consequences; ("mauvais traitement d'ordre affectif").

A review of a specified CIS report indicated that on an identified date and time, staff witnessed an identified staff member to have performed a specified action toward resident #015, against their will.

The identified staff member then put the resident into a chair in a specified area on the home area and continued to tell the resident that they had to have an identified activity of daily living (ADL) completed. The resident was witnessed attempting to go back to their room when the identified staff member performed a specified action and then tried to redirect the resident.

Staff intervened right away and one staff immediately reported the incident to an identified manager while the other staff stayed with the resident until the manager came to intervene. The staff that witnessed the incident indicated that the resident demonstrated identified responses.

During an interview with the Administrator, it was confirmed that the resident had not sustained any physical injuries; however, it was confirmed that the licensee failed to ensure that resident #015 was protected from abuse by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #006292-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 19. (1)] (508) [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, to be implemented voluntarily.

Issued on this 23rd day of February, 2018

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

Original report signed by the inspector.